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Attitudes Toward, and Perceptions of, Consulting Legal Counsel by Physical Therapy Professional Education Program Directors

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Attitudes Toward, and Perceptions of, Consulting Legal Counsel by Physical Therapy Professional Education Program Directors

by

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Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Doctor of Education

The University of Texas at Austin

August 2004

Dedication

I dedicate this dissertation with love to my best friend and wife of 32 years, Maria Josefa Scott. Thanks *mi amor* for making all of my dreams come true.

Acknowledgments

I first want to acknowledge my dissertation supervisor, Dr. Ronald M. Brown, Ph.D., Professor, Department of Educational Administration, for his patience, sage guidance, and encouragement throughout the process. The same recognition is due my committee members: Dr. William Lasher, Ph.D., Professor, Department of Educational Administration, Dr. Pedro Reyes, Ph.D., Professor, Department of Educational Administration, Dr. Gerald Torres, LL.M., H.O. Head Centennial Professor In Real Property Law, School of Law, and Dr. John Bennett, J.D., General Counsel, American Physical Therapy Association.

I also acknowledge my professional sisters and brothers in the law and in physical therapy, whose dedication to service to others, excellence in executing their duties, and zeal make them indispensable servants to their fellow human beings. Thank you for your service to others, and for modeling as sterling examples for me to emulate.

I acknowledge, too, the women and men from all the ages who have envisioned humankind as free, happy, and at peace with, and respectful of, one another. Thanks to God and my savior Jesus Christ for everything that I have and all that I am.

Attitudes Toward, and Perceptions of, Consulting Legal Counsel by Physical Therapy Professional Education Program Directors

Publication No. _____

Ronald William Scott, Ed.D.

The University of Texas at Austin, 2004

Supervisor: Ronald M. Brown

This study examines the attitudes toward, and perceptions of, consulting legal counsel by physical therapy (entry-level) graduate education program directors. Twenty in-depth interviews were conducted, with ten female and ten male respondents. Respondents represented the full range of physical therapy education program types – large, small, public and private. The semi-structured interviews included questions on: the legal environment; litigation; respondents' legal knowledge; access and barriers to legal counsel; costs and risks of legal consultation; respondent attitudes toward the law, legal system, and attorneys; the nature of consultations (systematic-proactive vs. *ad hoc*-reactive); attorney-client relations; attorney responsiveness and competence; satisfaction with counsel and consultative outcomes; and utilization of, and satisfaction with, outside legal advisors. Female and male respondents expressed different perspectives on their experiences with

consulting legal counsel for program-related advice. (Note: These results should not be interpreted as representative of the physical therapy education program director population in general. The results apply only to these twenty respondents.) Among other considerations, females in the study considered their legal environment less complex, and experienced fewer legal actions than their male counterparts. They received more legal education, and had greater direct access to institutional legal counsel. Female respondents viewed the law, legal system, and attorneys more favorably than males. Their legal consultations were more often systematic vs. *ad hoc*. Female respondents were less likely than males to view their institutional attorney-client relationships as confidential, and to characterize institutional legal counsel as their fiduciaries (acting in their personal best interests). They were more aware of when the attorney-client relationship may be breached by counsel. Female respondents were less satisfied with their institutional attorneys than males, but more often believed that consultative outcomes are positive. An interrelationship digraph and system schematic were created, delineating system inputs (legal milieu and access to counsel), mediating drivers (nature of legal advice and respondents' knowledge of the law) and outcomes (attorney-client relations and respondents' satisfaction with consultative outcomes), and system outcomes (respondents' perceptions of the law and attorneys, and their satisfaction with legal counsel). Recommendations include, among others, more and better systematic legal education for physical therapy education program directors, and more effective attorney-client relations, especially including mutual education, listening, respect, and support.

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Chapter 1

Introduction

Background

Physical therapy education program directors, like all health care providers, educators, and other professionals face formidable legal responsibilities incident to their official duties. From academic malpractice and related liability concerns incident to teaching, to health care malpractice liability associated with clinical practice activities, to business, employment, intellectual and real property law issues, physical therapy education program administrators confront the panoply of complex legal issues on a daily basis.

Because physical therapy education program directors are educated as clinical health care professionals and researchers, they may lack adequate professional preparation to deal effectively with the legal problems, issues, and dilemmas that they face in their education environments. Once in place as program directors, they may not receive adequate institutional preparation and support to help them confront these issues. Physical therapy education program directors may face institutional barriers to access to legal counsel for advice on program-related issues, and may further be limited by their own or by the public's possible negative biases against attorney-advisors. The modern day legal environment is complex, and the consequences of inappropriate action or inaction are potentially devastating to all parties involved.

What complicates the legal environment all the more is the fact that the law is constantly

subject to change. Legal mandates directly affect health professional education program administrators, who must comply with them, or risk civil, administrative, and even criminal liability for noncompliance. The adage "ignorance of the law is no excuse" applies with full force to health professional educators, just as it does to all members of society.

Because the United States is the most litigious nation in world history, both systematic and ad hoc consultation with legal counsel are requisites for effective business-related interpersonal relations and for liability risk management for all professionals, especially including health professional education program directors. To be maximally effective, legal advice should be solicited and obtained both proactively, for programmatic planning purposes and development of liability risk management strategies and tactics, and reactively, in response to specific problems, issues, and dilemmas with legal dimensions.

Throughout United States history, attorneys have had a decidedly negative public and press image. Alex de Tocqueville said in 1840, "Lawyers in the United States form a power that envelops society as a whole, penetrates into each of the classes that compose it, works in secret, acts constantly on it without its knowing, and in the end models it to its own desires." Author-journalist Catherine Crier (2002) opines that "Lawyers dominate our government [and] have their finger in every pie. They have turned the law into an instrument of tyranny." (pp. 181-182). Author-researcher Philip K. Howard (1994) believes that the "law has replaced humanity [and has made us] a nation of enemies." (pp. 22, 113).

From Shakespeare's admonition in Henry VI (1598), "First thing we do is kill all the lawyers" to Erin Brockovich's (2000) assertion, "I hate lawyers; I just work for them," attorneys at law have borne the brunt of public ire against the legal system.

Purpose

This qualitative study – one of first impression – examines in depth the attributes of the professional relationship between physical therapy professional (entry-level) education program directors and their consulting legal counsel, as the relationship concerns official, program-specific legal problems, issues and dilemmas. In the litigious professional operational environment of physical therapy education program directors, effective utilization of consulting legal counsel is a requisite for survival.

The study population is limited to graduate-level physical therapy program directors. Baccalaureate-level programs ceased to be accredited by the Commission on Accreditation in Physical Therapy Education in 2002, and no longer exist.

The specific purposes of this study are: (1) to identify and assess access to, and utilization of, consulting legal counsel (including gender differences, if any) by physical therapy professional education program directors; (2) to identify and assess attitudes and perceptions of physical therapy education program administrators toward counsel (including gender differences, if any) and determine whether or not these attitudes and perceptions impede the attorney-client relationship and/or consultative processes and outcomes; and (3) to identify and disseminate ways to improve the attorney-health professional education program director-client professional relationship and consultative outcomes.

The results of this study will provide a basis for improved consultation processes and outcomes, and attorney-client relations, between physical therapy education program directors

and their consulting legal counsel. The study will also contribute to the body of knowledge involving attorney-professional client relations and consultative outcomes generally.

Research Questions

The following research questions are addressed in this study:

1. What are the attitudes and perceptions of physical therapy education program directors toward consulting legal counsel regarding program-related issues?

2. Do the attitudes and perceptions of physical therapy graduate program directors toward consulting legal counsel adversely affect the attorney-client relationship and/or consultation outcomes?

3. What processes can be employed to foster optimal attorney-client relations and consultation outcomes?

Chapter 2

Review of the Literature

Physical therapy educational program administrators possess the same attributes of physical therapy professionals from the other two principal domains of physical therapy practice – clinicians and researchers. Physical therapy education program directors are simultaneously academicians and policy makers/implementers, business and financial managers, primary care clinicians, and clinical, management, and/or educational consultants.

Approximately twenty-five percent of physical therapy professional education programs offer a faculty clinical practice component in their programs, within which patients and clients receive physical therapy intervention (Harris, 2000). For program administrators operating in such environments, the legal complexity of their domains of operation is complicated even more by considerations of potential clinical health care malpractice liability, the procurement and maintenance of adequate professional and premises liability insurance, considerations of immunity from liability, the drafting of business contracts for care with patients and others, monetary reimbursement for clinical services, interaction with third party payers and governmental and clinical accreditation entities, required peer review and other oversight activities, and other parameters of routine health professional clinical practice administration. In such a complex, mixed professional education-health clinical practice environment, the need for systematic and *ad hoc* legal consultation is even more acute.

Physical Therapy: Professional Attributes and Legal Interface

The physical therapy profession is commonly thought of as a rehabilitation discipline; however, from its inception, it has always encompassed health care activities that fall outside the ambit of physical rehabilitation, such as wound care, cardiopulmonary and preventive interventions, and patient/client education, among a myriad of other activities. As such, "physical therapy" is difficult to define.

A Model Definition of Physical Therapy, developed by the Federation of State Boards of Physical Therapy, and adopted by the Board of Directors of the American Physical Therapy Association in 1993, defined physical therapy as follows:

> Physical therapy means the assessment, evaluation, and treatment and prevention of physical disability, movement dysfunction and pain resulting from injury, disease, disability, or other health-related conditions. Physical therapy includes: (1) the performance and interpretation of tests and measurements to assess pathophysiological, pathomechanical, electrophysiologic, ergonomic, and developmental deficits of bodily systems to determine diagnosis, treatment, prognosis and prevention; (2) the planning, administration, and modification of therapeutic interventions that focus on posture, locomotion, strength, endurance, cardiopulmonary function, balance, coordination, joint mobility, flexibility, pain, healing and repair, and functional abilities in daily living skills, including work; and (3) the provision of consultative, educational, research, and other advisory

services.

> The therapeutic interventions may include, but are not limited to, the use of therapeutic exercise with or without assistive devices, physical agents, electricity, manual procedures such as joint and soft tissue mobilization, neuromuscular reeducation, bronchopulmonary hygiene, and ambulation/gait training.

The Model Definition above became dated, in part, because of the publication by the American Physical Therapy Association in November 1997 of the *Guide to Physical Therapist Practice*, within which words like "assessment" and "treatment" were supplanted by broader inclusive terminology such as "examination" and "intervention," within which the former terms are components. The *Guide,* although not intended to represent a formal clinical practice guideline or the legal standard of care, has established common terminology and recommended standards for patient/client examination, evaluation, diagnosis, prognosis, and intervention which will form, or at least evidence, the legal standard of care for physical therapy practice.

The *Guide* does a commendable job of explaining the relative roles of physical therapy professionals and the scope and breadth of physical therapist and physical therapist assistant practice, because it does so using, to the extent feasible, lay-person terminology, which is also critically important for physical therapists and assistants to utilize in their communications with patients and clients and their significant others, and with relevant others. For example, in the *Introduction,* the *Guide* describes the professional participants and practices as follows:

As essential participants in the health care delivery system, physical therapists assume leadership roles in rehabilitation services, prevention and health maintenance programs, and professional and community organizations. They also play important roles in developing health care policy and appropriate standards for the various elements of physical therapist practice to ensure availability, accessibility, and excellence in the delivery of physical therapy services. The positive impact of physical therapists' rehabilitation, prevention, and health promotion services on health-related quality of life is well accepted. Physical therapy is covered by almost all federal, state, and private insurance plans.

As clinicians, physical therapists engage in an examination process that includes taking the history, conducting a systems review, and administering tests and measures to identify potential and existing problems. To establish *diagnoses* and *prognoses,* physical therapists perform *evaluations* that synthesize the examination data. Physical therapists provide *interventions* (the interactions and procedures used in treating and instructing patients/clients), conduct reexaminations, modify interventions as necessary to achieve anticipated goals and desired outcomes, and develop and implement discharge plans. Physical therapy includes not only the services provided by physical therapists but those rendered under physical therapist direction and supervision.

History of Physical Therapy in the United States

Note: Background material on the history of physical therapy derives in large part from Murphy, W. (1995). *Healing the generations: A history of physical therapy and the American Physical Therapy Association.* Alexandria, VA: American Physical Therapy Association and from Bicentennial Issue (1976). *Physical Therapy*, *56(1):* 1-146. The author is grateful to the American Physical Therapy Association for its kind permission to reprint, quote, and paraphrase this historical material.

While the application of physical therapy to illnesses and injuries may be generically as old as humankind, the history of physical therapy as an organized profession in the United States is of relative recent vintage. A single pathological condition was the primary genesis of the physical therapy profession in the late 1800s and early 1900s. That condition was the recurrent world-wide epidemic of infantile paralysis, or poliomyelitis, which seriously affected children in the United States for the first time (regionalized to New England) in 1894. Subsequent polio epidemics affected children in the same geographic region in 1914 and 1916.

Physicians and surgeons, including Dr. Robert Lovett, a prominent New England-based orthopedist, began to recruit European-educated *gymnasts* and American-educated physical educators to assist doctors and nurses in meeting the physical rehabilitation needs of polio patients and their families in the United States. One of the first such professionals to be formally recognized in the United States as a "physical therapist" was Mary McMillan.

Mary ("Mollie") McMillan was born in Hyde Park, Massachusetts in 1880 and was educated in Liverpool, England, after her family sent her to live with Scottish relatives following

the death from consumption (tuberculosis) of her mother and older sister in 1885. After graduating from Liverpool University and Liverpool Gymnasium College, Mollie studied corrective exercise science on-the-job under prominent European physicians and surgeons. She returned to Liverpool and worked primarily with children with poliomyelitis and scoliosis and other developmental conditions.

World War I was the next impetus for growth for physical therapy. Mary McMillan served in the British and American armies during World War I as a physical rehabilitation specialist and "reconstruction aide," respectively. She, along with professional colleagues like Margaurite Sanderson, promoted the concept of physiotherapy as a profession to American military commanders and civilian leaders, particularly Surgeon General William Gorgas. Gorgas authorized the establishment of a Division of Special Hospitals and Physical Reconstruction, which McMillan led.

Along with occupational therapists and dieticians, which later would form the core of the Army Medical Specialist Corps, physical therapy reconstruction aides were recruited and educated to serve the physical and vocational rehabilitation needs of military service personnel. Physical therapy reconstruction aides were educated at one of seven War Emergency Training Centers, including Walter Reed Medical Center in Silver Spring, Maryland; four centers located in Boston and New Haven, Connecticut; Columbia University, New York; the Kellogg Normal School, Michigan; and Reed College, Portland, Oregon.

As a representative example, the Reed College program was a three-month program which became the model for early post-war physical therapy education. Its curriculum consisted of 457 hours of classroom instruction in human dissection anatomy, physiology, kinesiology,

therapeutic exercise, massage, hydrotherapy, and ethics. The 800 students – all women, and referred to as the "Reed girls" (Murphy, 1995, p. 54) – also received 163 contact hours in clinical internship experiences. Students could also take French as a humanities elective.

After World War I, Mary McMillan and 244 of her Reconstruction Aide colleagues formed the American Women's Physical Therapeutic Association in 1921 (Myers, 1995, p. 4). The founding meeting of the association was held at the famous Keens Chophouse Restaurant at 72 W. 36th St., New York City, a venue that until 1901 did not welcome women, until British actress Lillie Langtry sued and won the legal right for women to be served there (Keens, 1999, p.7).

The charter American physical therapy professional association did not admit men. Its name was changed to the American Physiotherapy Association, and its charter amended in 1922, so that men could join. (Several men had been educated and served as reconstruction aides during World War I.)

According to McMillan, the domain of physical therapy practice in 1921 included four specialties: therapeutic exercise, hydrotherapy, and massage (Scully and Barnes, 1989, p. 11). Education programs between World Wars I and II were few in number and largely hospital-based and non-degree-awarding.

At the advent of World War II, there ensued emergent reemphasis on physical therapy education. Some 1632 physical therapists served during the Great War. Post-World War II, the number and quality of professional education programs proliferated. This growth was fostered again by recurrence of poliomyelitis epidemics post-World War II, and the relative dearth of physicians and concomitant need for physician surrogates.

Today, the domain of physical therapy clinical practice ranges from general practice to highly specialized practice, covering the human life span from neonates through geriatric clientele. In 47 states, physical therapists may examine and/or intervene for patients without physician or other provider referral or consultation (Cooperman, 2004). The parameters of this "direct access" to patient populations vary widely from jurisdiction to jurisdiction. (The three non-direct access states are: Alabama, California, and Indiana. (Larson, 2004).)

Representative Professions and Support Professionals

While it may seem self-evident that licensed physical therapists are the alter ego of the profession of physical therapy, in fact, the discipline "physical therapy" is comprised of two distinct classes of professionals: physical therapists and physical therapist assistants. Each discipline is characterized by formal post-secondary education (physical therapist assistants at the associate level; physical therapists at the graduate level) and each possesses relative attributes of the classic professions.

The classic definition of a profession is that its members: (1) possess a defined body of knowledge or expertise; (2) exercise a degree of autonomy, or self-determination, over matters pertinent to their discipline; (3) undergo formal education processes to acquire practice competencies; (4) conduct research activities to validate and refine their professional practice; (5) recognize advanced member competency through certification or other activities; and (6) promote public welfare through their service (Fleming, 1987).

Traditionally, only three classic professions were recognized: the practices of law and

medicine, and the ministry. Modernly, however, more than three classes of professionals exist in society, including, among others, physical therapy professionals. As modern professionals, physical therapy professionals exercise practice autonomy over activities within their legal scope of practice.

In addition to licensed physical therapists and physical therapist assistants, physical therapy is carried out by extenders working under the direction of licensed physical therapists, including, but not limited to, certified athletic trainers and exercise physiologists. Physical therapy aides augment the professional physical therapy team by providing patient support services, such as preparing patients and equipment for service delivery by physical therapists and/or assistants, assisting in interventions as allowed by law and customary practice, and sanitation of equipment and facilities, among others.

A salient political issue involving the term "physical therapy" is whether health professionals other than physical therapists and assistants may lawfully and ethically carry out "physical therapy" activities with patients and clients. This issue has resulted in litigation with complementary health professionals and associations, and is not finally resolved. This issue turns in large part on whether the term "physical therapy" is generic in nature, or exists for exclusive utilization by licensed physical therapists and their assistants.

Occupational therapists have a domain of practice that is very close to that of physical therapists. Occupational therapists were originally reconstruction aides like physical therapists during World War I. Post-World War I, they focused their professional efforts on optimization of patients' activities of daily living and on supplementing mental health professionals' therapeutic interventions (APTA, 1994). Other health professionals, including athletic trainers,

chiropractors, corrective therapists (exclusively within the Veterans Administration system), nurses, physicians, osteopaths, and recreational therapists, also carry out professional activities that may encroach upon the legal domain of physical therapists.

Licensing, Certification, and Credentialing

Licensing, certification, and credentialing of physical therapy professionals denotes special professional and legal status for those so recognized. Licensing is public recognition of special professional status, typically granted by state licensing boards and authorities. While physical therapists are required to be licensed in order to practice their profession in all fifty states, physical therapist assistants are licensed in many, but not all states.

Many or most states grant license by reciprocity for physical therapy professionals licensed in other states, without the need to retake a licensing exam. However, before engaging in physical therapy practice in any state, physical therapists and assistants must be licensed in that state. Initial licensing in a gaining state may involve the issuance of a temporary license, which typically expires (or must be renewed) after a relatively short time period, e.g. after six months.

There are several other issues surrounding health professional licensing that are of importance to physical therapy professionals. There has been, in public fora over the past few decades, a sense that licensing laws have become too pervasive. The principal purpose of health professional licensing laws is to protect the patient-public from unqualified and unsafe providers. State legislatures have come to believe that not all classes of health care professionals require

licensing for public protection (and that it is too burdensome a system to administer), and for that reason, there may be a trend away from continued proliferation of health professional licensing laws.

Another licensing law issue concerns the requirement for federal systems and entities to respect state licensing and other administrative practice requirements. The Supremacy Clause in Article VI, Section 2 of the federal Constitution subordinates conflicting state law to governing federal laws and regulations. For that reason, military (and perhaps other federally-employed) physical therapists practicing in any state may not be limited in their official military (federal) practice by that state's licensing laws and administrative rules and regulations, since they are governed principally by federal law pursuant to Article I, Section 8 [concerning Congress' plenary power to "raise, support, and maintain" military forces] and Article VI of the Constitution.

Another important licensing issue concerns practice across state lines. The internet has created consultative health professional practice opportunities nation- and worldwide, however, such practice in states in which one is not licensed may give rise to criminal liability, adverse administrative actions affecting licensing, and ethics adjudications by professional association entities. Before engaging in such practice across state lines, physical therapy professionals must practice effective proactive liability risk management, and seek and obtain legal advice on its propriety and legality (Bennett, 1997).

Certification of health professionals serves as a private sector analog to public sector licensing. Certification of health care professionals may be an alternative or a supplement to licensing, and, like licensing, serves to validate individual provider competence. Many physical

therapists and assistants are dually credentialed as licensed physical therapy professionals and certified athletic trainers. Athletic trainer certification is administered by the National Athletic Training Association.

Physical therapists having extensive clinical experience may also become board-certified by the American Board of Physical Therapy Specialties (ABPTS). Currently, the ABPTS offers certification through examination and professional portfolio review in the following clinical specialties:

- Cardiopulmonary physical therapy (CCS)
- Clinical electrophysiology (ECS)
- Geriatric physical therapy (GCS)
- Neurological physical therapy (NCS)
- Orthopaedic physical therapy (OCS)
- Pediatric physical therapy (PCS), and
- Sports physical therapy (SCS)

Board-certified physical therapist-clinical specialists are entitled (and required) to use the specialty designator listed above after their "PT" designation (their professional analog to "MD" or "JD" designators for physicians and attorneys, respectively). Periodic recertification is required in order to maintain board-certification status. Requirements for recertification vary from specialty to specialty.

Business, Organizational, and Professional Ethics

As health professionals and business persons working within organizations, physical therapists and physical therapist assistants in any practice setting, from educational institutions to clinical practice, are governed by professional, business, and organizational ethical standards that guide their practices. Resultant practice problems, issues, and dilemmas may arise on a recurrent basis for these professionals when professional, business, and organizational ethical standards and mandates come into conflict.

What are "ethics"? Ethics are standards of conduct governing official behavior. For health care professionals, the principal classification of behavior affected by ethical standards involves interpersonal behavior, i.e. how to interact with patients and clients, professional students, coworkers and consultants, third party payers, and a multitude of others, on an ongoing basis (Scott, 1998).

How do ethics differ from morals? While ethical standards are grounded in moral beliefs, they are different and narrower than morals in general. Moral beliefs are personal beliefs about important life issues, such as religion, abortion, the death penalty, commitment to marriage and children, and similar matters. Ethics represent viewpoints on important matters related to one's official conduct, such as within a profession, occupation, or business organization (Richardson, 1993).

Every individual has notions of what his or her professional conduct should be. These ideals form individual ethics. Groups of individual professionals and workers also formulate work place standards of conduct. For business organizations and systems, these (usually written)

standards constitute organizational ethics. An occupation or cluster of related occupations may also develop ethical standards of conduct, which make up business ethics. A limited number of professional disciplines even develop and constantly refine professional ethical standards of conduct, such as the two professions within physical therapy – physical therapists and physical therapist assistants – with their Code of Ethics and Standards of Ethical Conduct for the Physical Therapist Assistant, and interpretive *Guide for Professional Conduct* and *Guide for Conduct of the Affiliate Member*, respectively.

The differences in focus between and among business, organizational, and professional ethics result mainly from the nature and perception of duties owed by constituent members to clients served by the organization, business, or profession. While businesses generally may have business ethical codes requiring fair dealing with customers and high quality product and/or service delivery, professions focus on the fiduciary duty owed by members of the professions to clients. A fiduciary duty involves a special duty, in fact, the highest possible duty undertaken by anyone on another's behalf. A fiduciary voluntarily agrees to subordinate personal interests in favor of the best interests of clients served. A licensed or certified health professional fiduciary puts the interests of his or her patients above all others, including those of employers, payers, and her or his own interests. Physical therapists and physical therapist assistants are fiduciaries to their patients and clients, just as educators in colleges and universities are fiduciaries to their students and dissertation candidates.

How does a physical therapist or physical therapist assistant deal with professional ethical problems, issues, and dilemmas that arise in practice? While there are many models described in the professional literature for ethics resolution, one simple one is the systems approach to

professional ethical decision making.

Relative to health professional ethical decision making in any practice setting (clinical, research, or educational), the first step in using the systems approach is to identify a problem, issue, or dilemma (in increasing order of severity and immediacy) having ethical dimensions. Next, inputs are identified. These consist of facts, unknowns, and assumptions about the problem, issue, or dilemma. After that, possible solutions to the problem, issue, or dilemma are identified, and the optimal solution identified by the person taking action, that option is implemented. The systems approach to health professional ethical decision making includes a feedback loop, through which the actor carefully monitors the chosen solution for effectiveness, and modifies (or discards and replaces) it, as necessary.

Professional Ethical Standards

There are two primary written resources delineating the professional ethical duties owed by physical therapists and physical therapist assistants to patients, clients, professional students and colleagues, and others. Both are promulgated by the American Physical Therapy Association, the sole professional organization representing physical therapists and assistants. These ethical guidelines are the Code of Ethics and interpretive *Guide for Professional Conduct* (governing the official conduct of licensed physical therapist-members of the American Physical Therapy Association) and Standards of Conduct for the Physical Therapist Assistant and interpretive *Guide for Conduct of the Affiliate Member* (governing the official conduct of physical therapist assistant-affiliate members of the American Physical Therapy Association).

What written or unwritten professional ethical standards govern the conduct of physical therapists and physical therapist assistants who are not members of the American Physical Therapy Association? Physical therapy licensure statutes in all states are modeled, at least in part, after *The Guide for Professional Conduct*. It may also be that the provisions of *The Guide for Professional Conduct* and *The Guide for Conduct of the Affiliate Member* are more than American Physical Therapy Association private standards, because they delineate universally applicable professional ethical standards for physical therapy professionals. As such, they might be used by courts, licensing boards, and other administrative bodies to assess the conduct of even non-American Physical Therapy Association-members.

The *Guide for Professional Conduct* and *The Guide for Conduct of the Affiliate Member* share unique attributes among health professional codes of ethics. For example, it is rare to find separate ethics codes for licensed primary health care professionals and licensed assistants, as exists with these two codifications. One problem associated even with these two codes is the fact that other extender personnel, including athletic trainers, physical; therapy and rehabilitation aides, and health professional students, are not expressly included in the coverage of either code's provisions. The Ethics and Judicial Committee and Board of Directors of the American Physical Therapy Association work on revisions to both documents on an ongoing basis.

Sources of Legal Obligation for Licensed Health Professionals

There are at least five categories of sources of legal obligation for licensed health care professionals. These include: constitutional mandates; legal obligations emanating from

statutory laws; judge-made (trial) case law pronouncements within the jurisdiction of the provider; administrative agencies rules and regulations; and legal duties associated with secondary source authorities (Scott, 1997).

There is a hierarchy of precedence for legal authorities that must be obeyed. At the pinnacle of this hierarchy is federal constitutional law. The federal Constitution is known as the "supreme law of the land." With few exceptions, the legal mandates spelled out in the Constitution apply only to federal, state, and local governmental entities. One notable exception to this principle is the Thirteen Amendment to the Constitution, which prohibits involuntary servitude of one person by another – whether imposed by a governmental entity or a private citizen or business entity.

An important federal constitutional personal right affecting physical therapy is the constitutional right of individual privacy. As important as this right may seem, it is not one of the enumerated personal liberties found in the Bill of Rights and body of, and amendments to, the Constitution. Rather, the constitutional right to privacy is an implied right of recent origin, and the subject of ongoing controversy among legal scholars. The constitutional right to patient privacy affects what use governmental entities and officials may make of patient-related information, including medical and billing records, whether on paper or computerized.

There is no express federal constitutional right to education, health care or to work. These seemingly fundamental rights may, however, exist within state constitutions and federal and state statutes.

State constitutions may afford greater rights to citizens and residents of particular states than does the federal Constitution. State constitutions may not, however, take away rights

granted to individuals under federal law.

Statutes are laws enacted by Congress or by state legislatures. Examples of important federal and state statutes affecting physical therapy professionals and their patients include: the Americans with Disabilities Act of 1990 (prohibiting access and employment discrimination of disabled persons); the Civil Rights Act of 1964 (Titles VI and VII of which prohibit education-based and employment discrimination based on race, ethnicity, religion, gender or national origin, respectively); the Family Education Rights and Privacy Act of 1974 (protecting the privacy rights of students), the Family and Medical Leave Act of 1993 (providing employee job security in the face of illness, injury or pregnancy); the Occupational Safety and Health Act of 1970 (promoting and enforcing work place safety); the Social Security, Medicare and Medicaid Acts; and state physical therapy practice acts (delineating the permissible scope of licensed physical therapy practice).

Judge-made case law consists of legal trial and appellate court opinions from specific civil and criminal legal cases. These judicial decisions have the force of law, and are, when issued by the highest-level state courts, precedent which must be followed by lower-level courts within the state. Important examples of judicial cases affecting physical therapy professionals include health care malpractice civil cases brought by patients against providers and/or institutions for alleged injuries, and criminal cases brought against individuals and/or institutions by local, state, or federal prosecutors for alleged wrongdoing.

Physical therapy professionals in all practice settings – like business men and women and citizens in general -- have the greatest exposure to the legal system through interactions with administrative agencies at local, state, and federal levels (Davis, 1994, pp. 6, 7) . Administrative

agencies exercise power over business affairs, delegated to them by Congress and/or state legislatures. Examples of important administrative agencies impacting physical therapy include: the Equal Employment Opportunity Commission [EEOC](concerning the equal and fair treatment of employees and job applicants by employers); the Internal Revenue Service (concerning federal tax law), and the Occupational Safety and Health Administration (concerning work place [including educational institutions] safety).

Important secondary sources of legal duty and of the professional standard of care for physical therapy professionals include: accreditation standards, such as those issued by the Joint Commission on the Accreditation of Health Care Organizations [JCAHO], the Commission on Accreditation of Rehabilitation Facilities [CARF], and the Commission on Accreditation in Physical Therapy Education [CAPTE]; written institutional and association practice standards and guidelines, including the *Guide to Physical Therapist Practice*; unwritten customary practice standards; and professional, organization, and business ethical standards, including the *Guide for Professional Conduct* and *The Guide for Conduct of the Affiliate Member.*

Model Practice Act

The Model (Physical Therapy) Practice Act is a document issued by the Federation of State Boards of Physical Therapy, a private, non-profit 506(c) [trade association] organization made up of representative state physical therapy licensing boards from the 50 states. The purpose of the Model Practice Act is to foster uniformity among state licensing laws governing the practice of physical therapy. As has occurred in the legal profession with the American Law

Institute's Model Rules of Professional Conduct, it is expected that the states will adopt the Model Practice Act in whole or in part over time.

Rights and Duties of Patients, Health Professionals and Health Professional Students

Under United States federal, state, and local laws, individuals and business entities possess legal rights and are simultaneously encumbered with legal obligations. Rights and duties are the "heads" and "tails" of a two-sided coin.

What is the primary duty of a clinical health care professional toward his or her patients? Is it to effect a cure for a disease, or to reverse the adverse consequences of an injury or alleviate an impairment or impairments? No. Although these goals of intervention represent the hopes and aspirations of both providers and patients, they are not what is basically required of clinical health care providers. What clinical health care professionals must do, however, is utilize their best skills and exercise their best clinical judgment to attempt to effect an optimal therapeutic result for patients under their care.

Specific patient rights and responsibilities may be delineated in institutional literature, such as handouts, or in universal documents, such as patient bills of rights and duties posted in virtually every clinical setting in the United States. Even without such written guidance, patients do have legal responsibilities toward their health care professionals. The principal duty of patients is to pay for health care services rendered on their behalf, most commonly through third party intermediaries, or insurers.

Health care clinical professionals should also make an express (i.e. clearly stated) part of

their care contracts with patients the patient's duty to cooperate to the maximal extent that is feasible and safe with the agreed-to plan of intervention. As such, patients become, as they in fact are, stakeholders in their own health care and recovery.

Civil Rights Laws

At federal, state, and local or municipal levels, civil rights statutes, case law, and administrative rules and regulations are in force to protect the basic civil rights of all citizens and legal aliens within the territory of the United States. The most important of these protections at the federal level include: the Age Discrimination in Employment Act of 1967, the Americans with Disabilities Act, the Civil Rights Act of 1964, and the Family and Medical Leave Act. These federal statutes are briefly described below.

The Age Discrimination in Employment Act of 1967 (ADEA) protects older workers, age 40 or greater, from employment-related discrimination based on their age. This law, like those described below, protect workers from discrimination at all stages of employment, from recruitment and application for employment through retirement and/or termination of employment. The Americans with Disabilities Act of 1990 (ADA) expands the ambit of protected classes of persons for purposes of federal civil rights protection to include those customers and employees having physical or mental disabilities. Title I of the ADA is the analog of the ADEA and of Title VII of the Civil Rights Act of 1964 (below), in that it protects disabled employees and job applicants from employment discrimination. Title II of the ADA extends civil rights protection to disabled persons utilizing public facilities, such as airports, government

buildings, and public colleges and universities. Title II of the ADA mandates that "public accommodations," including physical therapy clinical facilities and private colleges and universities, be accessible to disabled patients and patrons.

Title VII of the Civil Rights Act of 1964 mandates that employers not discriminate in hiring or any other aspects of employment against any persons on the bases of race/ethnicity, religion, gender, or national origin. It is from the global concept of gender discrimination that laws and regulations prohibiting work place sexual harassment emanated. Sexual harassment, although seemingly obviously a form of gender discrimination, was not recognized by the United States Supreme Court for 15 years after its inclusion in Title VII. There are two basic types of work place sexual harassment. One is *quid pro quo* sexual harassment, in which someone in a position of authority coerces a subordinate to engage in sexual activity in exchange for favorable employment considerations, such as a pay raise or permission to attend continuing education courses. The other basic type of work place sexual harassment is "hostile work environment" sexual harassment, which does not necessarily involve a superior and subordinate as perpetrator and victim, respectively. Under this prong of sexual harassment, a perpetrator's conduct that substantially and objectively interferes with another worker's ability to carry out his or her duties constitutes sexual harassment. Under hostile work environment sexual harassment, anyone in the work place may be a perpetrator (including patients, for whose conduct management may be legally responsible)(Scott, 2000, 43).

Bases for Health Care Malpractice Liability

Health care malpractice is civil liability of a health care professional for patient injuries (physical and/or mental), with a legal basis for liability imposition (Scott, 1997, p. 29). The term health care malpractice is used herein instead of medical malpractice, which affects only physicians and surgeons. Modernly, a larger group of primary health care providers – including physical and occupational therapists, speech and hearing professionals, nurse practitioners, physician assistants, and others – may be claimed against or sued by patients in their own capacities for malpractice.

By 2000, approximately 30 physical therapy malpractice cases were reported in the legal literature (Scott, 2000, p. 184). The legal term of art "reported cases" refers to case law decisions of appellate, not trial level courts. None of these reported cases involves physical therapy educators or administrators specifically, and none is based on allegations of academic malpractice. In fact, all are grounded in allegations of professional clinical negligence, or substandard care delivery. Only one case emanates from a school setting, and that case involves the issue of vicarious liability for the conduct of a physical therapy aide (*Greening*, 1986).

The recognized legal bases for health care malpractice liability imposition include the following:

- Professional negligence, or substandard care delivery [Note that non-care-related negligence, e.g. a patient "slip and fall" on a wet surface, is <u>not</u> health care malpractice, but rather *ordinary negligence*.];
- Intentional care-related misconduct, including, among other torts, *battery* (harmful or

offensive patient contact) and *sexual battery* (conduct intended to arouse or gratify sexual desires of the provider or patient);

- Breach of a therapeutic contractual promise; and
- "Strict" (without regard to fault) liability for abnormally dangerous care-related activities or patient injury by dangerously defective care-related products or equipment [strict product liability].

The vast majority of health care malpractice claims and lawsuits involve allegations of professional negligence, or substandard care delivery. To prevail in a professional negligence health care malpractice case, a patient must prove the existence of the following core elements by a preponderance, or greater weight, of evidence (Keeton, 1984):

- A special duty owed by the defendant-provider toward the patient (This special duty becomes operational when the provider agrees to provide health professional services for the patient.);
- Violation of the special duty owed (by providing objectively substandard care delivery);
- "Causation" (proof that the substandard care delivery resulted in injury to the patient); and
- "Damages" (proof that the patient's injuries warrant the award of money in order to restore the patient, to the extent feasible, to the *status quo ante*).

Whether a defendant-health care professional met or violated practice standards in a

professional negligence legal case is established largely through expert witness testimony on the standard of care for the defendant's discipline and expert opinion on whether the defendant met or fell below minimally acceptable practice standards. Expert witness testimony on the standard of care may be supplemented by information in authoritative and reference texts and journals, and by written practice protocols and guidelines.

Health care malpractice liability is a form of *primary liability,* i.e. liability for the consequences of one's own conduct. Rehabilitation professionals and organizations may also be indirectly or *vicariously liable* for the official conduct of employees and volunteers, but not normally for the conduct of independent contractors and their staffs, so long as appropriate steps are taken to alert the public of the fact that such workers are contractors and not employees.

Corporate liability is another form of primary liability, under which a business entity, including rehabilitation clinics, education institution-based faculty practices, and other facilities, are legally responsible for certain administrative activities. These activities include, among possible others:

- Monitoring the quality of health care service delivery in the facility or facilities, whether rendered by employees, contractors, consultants, volunteers, or others; and
- Maintaining safe and secure premises for patients and others (Kearney, 1992).

While a rehabilitation services administrator bears primary responsibility for implementing and executing clinical risk management program initiatives, every professional and support team member bears personal responsibility for effecting liability risk management

on behalf of the organization. Clinical risk management initiatives include, among others:

- Safety programs designed to minimize injuries to patients, staff, licensees (business visitors) and others;
- Equipment calibration and ongoing safety inspections;
- Adverse incident reporting;
- Peer review and related patient care quality management processes; and
- Liability awareness education processes, including involving health law attorneys in continuing education as well as well as administrative and clinical decision making (Furrow, 2000, p. 129).

Patient Informed Consent to Physical Therapy Intervention

Patient informed consent is both a legal and professional ethical prerequisite to patient examination and health care intervention (Rozovsky, 1990). The duty to make relevant disclosure of care-related information to patients and obtain their express assent to examination and intervention is grounded in respect for patient self-determination, or autonomy over health care decision making. This paradigm of placing patient autonomy considerations above paternalism, or beneficence, is relatively new, and not one that health care professionals voluntarily adopted. It has been an activist judiciary in the United States during the twentieth century that has progressively and firmly mandated patient control over health care decision making.

Although the precise informed consent disclosure requirements vary from state to state,

the following core information must be conveyed to patients before a health-related examination or intervention:

- Information about the nature of the physical examination;
- Examination and evaluative findings;
- Patient diagnosis;
- Information about any recommended intervention, especially including disclosure of material risks of serious harm or complications associated with the recommended intervention;
- Benefits associated with a recommended intervention ("goals"); and
- Information about (i.e. relative benefits and risks) reasonable alternatives to a recommended intervention (Standards of Practice, 2000, IIIA).

After such disclosure is made, a primary health care professional must also solicit and satisfactorily answer patient questions about the proposed examination or intervention. Finally, a provider must formally ask for and obtain patient consent to proceed. All of the communication above, between provider and patient (or surrogate decision maker, if the patient lacks legal capacity to consent), must take place both in a language that the patient understands and at the level of patient understanding.

Disciplinary Actions and Processes

The American Physical Therapy Association has ethics jurisdiction over approximately 70,000 physical therapists and physical therapist assistants who are members of the professional association. A written complaint of possible unethical conduct on the part of member physical therapists or physical therapist assistants is the starting point for initiation of investigatory and disciplinary action, pursuant to the Procedural Document on Disciplinary Action of the American Physical Therapy Association (2004). The disciplinary process for physical therapists and assistants is analogous to the processes used by respective professional associations for attorneys and physicians.

A complaint may be made by anyone having knowledge (first-hand or otherwise, e.g. hearsay) of a suspected ethical violation by an association member. The written, signed complaint is forwarded to the state chapter president, who (1) forwards an informational copy of the complaint to the national-level 5-member Ethics and Judicial Committee [for which dissertation committee member Dr. Jack Bennett is staff liaison and legal advisor], and (2) makes an initial subjective determination as to whether or not the complaint is actionable. Acknowledgment of the complaint must be returned to the complainant by the chapter president within fifteen days of receipt. Along with acknowledgment, the chapter president is charged to advise the complainant that the respondent (professional charged) may have the right to learn the complainant's identity at some point in the process.

If an ethics complaint is non-actionable because an allegation does not involve a violation of the Code of Ethics or Standards of Ethical Conduct (i.e. lacks subject-matter jurisdiction), or,

if in the judgment of the chapter president, the allegation does not warrant judicial action, then the complaint is summarily dismissed by the chapter president. If the complaint is actionable, then the respondent-association member is notified of the charge(s) and of the specific provisions of the Code or Standards allegedly violated.

A chapter president may initiate judicial action *sua sponte* (at his or her own initiative without a written complaint), based on public information. Proof of commission of a crime related to a member's professional status, or of a felony, or of revocation of professional licensure, is *prima facie* (presumptive) evidence of an actionable ethics violation and triggers mandatory interim suspension of membership until the Ethics and Judicial Committee takes follow-on action at its next regularly scheduled (semiannual) meeting.

In all other actionable ethics cases, the chapter president forwards the case file to the chapter ethics committee for processing. The chair of the state chapter ethics committee then appoints an impartial investigator (association member or other appropriate person) to conduct a comprehensive, unbiased investigation of the charges against the respondent. At the conclusion of this process, the investigator makes findings of fact (but neither conclusions nor recommendations), compiles the investigative file, and forwards it to the chapter ethics committee for further action.

If, after receipt and analysis of the investigative file, the chapter ethics committee determines that charges against a respondent are unsubstantiated, the chapter ethics committee may dismiss the complaint, under which option the respondent does not have the right to learn of the name of the complainant. Otherwise, the respondent is notified of his or her right to a copy of the investigative file and to a hearing on the charges.

With or without a hearing, the chapter ethics committee makes specific conclusions and recommendations on the charges against a respondent, which may (and must include) either a recommendation for dismissal of the charges or further disciplinary action by the Ethics and Judicial Committee. Disciplinary actions by the Ethics and Judicial Committee include: no official action, written reprimands, membership probation (from six months to two years), suspension of membership (of one year duration or longer, with or without conditions for reinstatement), and expulsion from membership in the American Physical Therapy Association.

Once properly notified of the chapter ethics committee recommendations, a respondent has the right to request a hearing before the Ethics and Judicial Committee at its next regularly scheduled semiannual meeting in Alexandria, Virginia. At this hearing, as at the state level, a respondent may be accompanied by legal counsel, who may serve only as a silent advisor to the respondent during the proceedings. A non-attorney spokesperson, however, may present a defense on the respondent's behalf before the Ethics and Judicial Committee.

With or without a hearing at the national level, the Ethics and Judicial Committee takes action on a complaint, as follows: the Committee may adopt the recommendation of the state chapter ethics committee and award the appropriate sanction, award a less severe sanction, dismiss charges outright, or remand (return) the case to the chapter ethics committee for further action.

After final Ethics and Judicial Committee action, a respondent has the right to appeal their decision to the Board of Directors of the American Physical Therapy Association within thirty days. The Board may affirm the prior decision, award a less severe disciplinary sanction, dismiss charges against a respondent, or remand the case to the Ethics and Judicial Committee

for further specific action.

Once final, publication of disciplinary action takes place in association publications of general circulation. Published information is limited by policy to the name of the respondent, the disciplinary action taken, and the effective dates of the action. Beyond this summary information, the details of disciplinary action are confidential, and not disseminated to other entities without a court order compelling such disclosure.

The stigmatizing effects of suspension of membership or expulsion from the professional association are devastating and potentially career-ending, especially for prominent members and educational program faculty and administrators. Over the past decade, a growing number of ethics complaints by and against professional education program faculty have been lodged and adjudicated by the Ethics and Judicial Committee.

History of Physical Therapy Education Program Accreditation

The American Physiotherapy Association initially had autonomous accreditation responsibility for physical therapist professional education programs from 1923 to 1933 (Myers, 1995, p. 4). From 1934 to 1956, the Council on Medical Education and Hospitals of the American Medical Association accredited physical therapist professional education programs (as it did for most allied health education programs), at the request of the American Physical Therapy Association. From 1957 to 1963, the American Physical Therapy Association and the American Medical Association informally jointly accredited physical therapy education programs. This arrangement was formalized in 1964, and continued through 1976. In 1977, the

Commission on Accreditation in Education was formed by the American Physical Therapy Association, and it alone accredited physical therapy education programs from that time on. Its current name is the Commission on Accreditation in Physical Therapy Education. The Commission is recognized as an independent educational accrediting body by the United States Department of Education and the Council on Higher Education Accreditation.

The Commission on Accreditation in Physical Therapy Education is an autonomous division of the American Physical Therapy Association, and accredits and re-accredits entry-level physical therapist professional and physical therapist assistant education programs. Its current accreditation standards for physical therapy education programs is known as the

Evaluative Criteria.

Developing (newly-formed) physical therapist professional education programs are required, before admitting students to the professional phase of study, to obtain candidate status from the Commission on Accreditation in Physical Therapy Education, and must be approved by the Commission for initial accreditation before graduates are eligible to take the national licensure examination, a requisite for professional practice.

The *Evaluative Criteria* (2004) for program accreditation are specific and detailed. They are divided into four sections:

- Section 1: Organization
- Section 2: Resources and Services
- Section 3: Curriculum Development and Content, and

- Section 4: Program Assessment

Section 1 sets out the legal, administrative, and financial duties of sponsoring institutions of higher education, and the rights and duties of the institution, faculty, and students. Section 2 addresses the qualifications for program core and adjunct faculty, fiscal planning and management, administrative and support services, learning/library resources, and equipment and materials. Section 3 delineates the requisites of curriculum planning and acceptable curriculum content, in terms of didactic, clinical and research educational content areas.

Effective January 2002, the Commission on Accreditation in Physical Therapy Education only accredits post-baccalaureate education programs. This policy decision was based on multiple criteria, in particular, the fact that the professional scope and depth of clinical physical therapy practice has developed to the point that public safety demands expanded, graduate-level preparation for licensed physical therapists. Standard 3.9 of the *Evaluative Criteria* reads:

> The first professional degree for physical therapists is awarded at the postbaccalaureate level at the completion of the physical therapy program.

Section 4 of the *Evaluative Criteria* details the requisites for systematic, formal program assessment, from mission, philosophy, and goals to admissions, resources, and post-graduate placement and activities of graduates.

Program Directors and Legal Issues Confronting Them

Since 1998, physical therapist professional education program directors have been required by the *Evaluative Criteria* of the Commission on Accreditation in Physical Therapy Education to be licensed physical therapists and to possess doctoral degrees.

The legal environment facing physical therapy education program administrators is complex and volatile. As human resource and financial managers, academicians, clinicians, and researchers, they face daily the widest range of variegated responsibilities potentially affecting education program administrators (Kaplan, 1995).

Two diverse legal problem areas impacting physical therapy education program directors involve intellectual property and student admission, retention, and dismissal. Intellectual property refers to tangible and intangible personal creations, including, but not limited to, writings, computer software, and inventions. A patent is an exclusive grant to make, market, and use tangible inventions for a period of years. A trademark or service mark is a protected distinctive symbol representing a product or service, respectively. A copyright protects an author's expression of a creative idea. Two federal agencies – the Patent and Trademark Office and the Copyright Office – protect proprietary intellectual property interests. Student admission, retention, and dismissal decisions made by academicians and education administrators are afforded substantial deference by courts and legislators (Scott, 1997, pp. 248-249).

One of the most volatile program-related issues facing program administrators is that involving the scarcity of clinical education sites for professional students (which are not

traditionally reimbursed for mentoring, educating, and supervising students). A related legal issue involves the drafting, negotiation and administration of clinical affiliation agreements for placement of students at clinical education sites. Clinical affiliation agreements are formal contracts between education institutions and clinical facilities.

In recent times, these contracts have become more and more difficult to draft, reach agreement on, and administer. These difficulties involve such issues as the assignment of vicarious liability for student conduct (even though all professional physical therapy students are covered by mandatory professional liability insurance), and the relative rights and duties of the educational and clinical institutions, respectively. They universally require legal oversight in their development and implementation.

Consulting Legal Counsel: Attributes and Attitudes and Perceptions of Clients

The role of an attorney-advisor to a client is that of a fiduciary. Just as the clinical physical therapist is a fiduciary to his or her patients, and the physical therapist-educator is a fiduciary to students, the attorney is charged by law and professional ethics to place the best interests of clients above all others. There are two caveats to the legal fiduciary duty owed by attorneys to clients. First, attorneys are "officers of the courts," owing a high duty to the legal system and its integrity. As such, they may not aid clients in defrauding courts through lying or countenancing clients lying to courts. Second, attorneys have the duty or right [depending on the legal system] to breach client confidentiality concerning certain matters, such as the commission of future crimes.

The Preamble: A Lawyer's Responsibilities of the *Model Rules of Professional Conduct* (1994) delineates the range of roles that an attorney may play, *vis a vis* clients. The attorney is an advocate for clients' positions, and may not operate in environments in which there are conflicts of legal interests between or among clients. The attorney is also an evaluator (of circumstances) and a negotiator on behalf of clients.

The rationale for requiring attorneys to generally maintain client communications in confidence is that such a rule promotes free disclosure of information necessary for the attorney to be an effective client advocate, and facilitates respect for the legal system by all in society who enjoy such protection. The attorney-client confidentiality privilege is the strongest legal privilege in society.

Rule 1.3 of the *Model Rules* specifically addresses the organization as client, and complicates the professional relationship between physical therapy education program director and institution/system legal counsel. The fiduciary relationship in such cases is normally between the organization and legal counsel, and not between the program director and legal counsel. In cases of actual or potential conflicts of interest, education program directors may have to consult (at their own expense) with personal legal counsel for advice (Markey, 2002).

In August 2003, the American Bar Association (ABA) amended the Model Rules of Professional Conduct regarding corporate counsel. These amendments were based in large part on the ABA Task Force on Corporate Responsibility's Cheek Report, developed after the criminal legal case against WorldCom /MCI corporate officers. Amended Rules 1.13 (Organization as Client) and 1.6 (Confidentiality) refine the corporate attorney's role in "reporting up" (to the governing board) and "reporting out" (to government agencies) of

otherwise privileged information when that information is reasonably certain to defraud third parties and substantially injure their financial interests (Peregrine, 2004).

The legal profession has the most extensive history of voluntary commitment to rendition of *pro bono publico* professional service to clients lacking the ability to pay for services (Lardent, 1989). Rule 6.1 of the *Model Rules* enunciates the ethical *pro bono* standard for attorneys:

> A lawyer should render public interest legal service. A lawyer may discharge this responsibility by providing legal services at no fee or at a reduced fee to persons of limited means or to public service or charitable groups or organizations, by services in activities for improving the law, the legal system or the legal profession, and by financial support for organizations that provide legal services to persons of limited means.

The nonbinding "Comment" to Rule 6.1 of the *Model Rules* expounds on this ethical principle by stating:

> Every lawyer, regardless of professional prominence or professional work load, should find time to participate in or otherwise support the provision of legal services to the disadvantaged. The provision of free legal services to those unable to pay reasonable fees continues to be an obligation of each lawyer, as well as the profession generally.

Despite this level of professional responsibility, attorneys individually, and the legal profession generally, receive ongoing criticism by the public-at-large. From the Time magazine article titled "Are Lawyers Burning America?" (Press, 1995) (referring to the personal injury case won by a 79 year-old woman against McDonald's restaurant after she sustained serious third-degree burns from 170-degree scalding hot coffee) to the *Wall Street Journal* editorial "'Lawyer Fear' Harms Health Care (Volpintesta, 2000)," the public – all of whom are prospective legal clients– are barraged with communications blaming attorneys for society's systemic problems.

A survey of public opinion by the State Bar of Texas (1999) revealed that 89 percent of respondents believe that attorneys are necessary to protect individual rights and seventy-seven percent believe attorneys to be competent to carry out that role. Ginsburg (1991) offers advice on how to evaluate a consulting attorney, including querying the attorney about his or her area(s) of specialization, assessing compatibility, and avoiding conflicts of interest. Overman (1992) expands on Ginsburg's points by offering advice on how to work effectively with consulting legal counsel. Overman's advice includes: seeking advice proactively, actively participating in developing strategies and tactics, effectively utilizing alternative dispute resolution, and avoiding conflicts of interest, especially involving in-house vs. outside counsel.

Health care professional legal clients selecting and working with malpractice attorneys should educate legal counsel about the nature of their health discipline's practice. Scott (2000) and Rozovsky (1990) address the blending of legal and health professional education and ethics instruction in professional education programs as means to minimize distrust and animosity

between and among the disciplines.

This study is based, in part, on two prior survey research studies conducted by the author. In the first, the extent of legal education in physical therapy professional education programs was examined. Eighty-eight (76 percent) of 116 academic institutions with physical therapy programs were surveyed by mail or by phone. It was discovered that 94 percent of programs offered some form of legal education to entry-level students within the formal curriculum (Scott, 1990). Eighty-five percent of respondents devoted one to ten curricular hours to malpractice-related topics. In the second study, a survey was conducted involving baccalaureate and graduate physical therapy education program directors and their consulting legal counsel. One hundred one of 143 program directors responded to the survey, a 76 percent response rate. It was found that 89 percent of graduate, and 74 percent of baccalaureate, program directors had solicited legal advice. Fifty percent (17 of 34) of male, and 39 percent (21 of 54) of female, graduate program directors reported direct access to institutional legal counsel for advice (Scott, 2000).

Chapter 3

Method

Introduction

The research questions addressed in this study were: (1) What are the attitudes and perceptions of physical therapy education program directors toward consulting legal counsel regarding program-related issues?; (2) Do the attitudes and perceptions of physical therapy graduate program directors toward consulting legal counsel adversely affect the attorney-client relationship and/or consultation outcomes?; and (3) What processes can be employed to foster optimal attorney-client relations and consultation outcomes?

Qualitative research describes people's experiences in particular settings, with the aim of understanding their perspectives, often using their own words (Hammell, 2000; Heath, 1997). Phenomenological studies are value-determined naturalistic inquiries in which meaning is understood only by persons who experience it (DePoy, 1998). In classic phenomenological studies, the researcher conducts field research in natural settings, identifies patterns to describe data, and inductively deduces causes, consequences, relationships, and theories (Bailey, 1991; Patton, 1990; Lincoln & Guba, 1985). This study employs a phenomenological naturalistic model to assess attorney-physical therapy education program director-client relations from the clients' perspective, using in-depth interviews.

Inductive analysis is a process for making sense of interview data. It involves using

interview data to derive relational perspectives and theory (Lincoln & Guba, 1985, p. 333).

Trustworthiness of qualitative study data and results is ensured via four criteria (Lincoln & Guba, 1985, p. 218, 290). They are: credibility (analog to quantitative internal validity), transferability (external validity), dependability (internal reliability), and confirmability (external reliability, or objectivity). Credibility derives from investigator integrity and neutrality; prolonged engagement with, and persistent observation of, subjects; peer debriefing; member checking; and triangulation of data (Lincoln & Guba, p. 219). Transferability is achieved through a rich or "thick" description of data. Dependability and confirmability are realized through "auditing" of data, i.e. double-checking data through reduction, reconstruction, and synthesis during axial and theoretical coding.

In this study, credibility was optimized, in part, through investigator neutrality. The author strove to achieve systematic rigor in conducting interviews in a non-judgmental way; pre-identified and sublimated potential endogenous biases; and imparted appropriate prefatory statements to interviewees, establishing the phenomenological attitude of the study (Katz, 1987; pp. 36-37). Additionally, Jonathan Cooperman, JD, PT, a member of the open coding focus group, acted as a peer debriefer for data analysis. Underlying the presentation and interpretation of findings is the desire of this researcher to report as completely and truthfully as possible. Transferability derived from a thick description of solid data, heavily supported by direct quotes from interviews, presented so that readers would be able to understand and draw their own interpretations from them (Denzin, 1989). Dependability and confirmability derived from post-interview axial and theoretical coding of data.

Sampling

Purposeful sampling (Bailey, 1997, p. 136) of study participants was done to focus on: (1) those graduate-level physical therapy program directors who have utilized consulting legal counsel in the recent past (within twelve months of interview); (2) exploration of any significant differences in relationships between female and male physical therapy program directors and consulting legal counsel; and (3) achievement of maximum variation (comprehensiveness) in sampling of graduate physical therapy program directors across program types (large, small, public, private, urban, and rural).

Of the 201 physical therapy entry-level education programs, the following were eliminated from consideration for interview: baccalaureate programs; those presenting actual or potential conflicts of interest; and those within which legal counsel had not been consulted during the past twelve months. Sixty-five target programs were then triaged into geographic and other relevant categories. It was the intention of the author to cover every region of the United States in interviewing, to account for factors such as possible geographic differences in customary relations between program directors and legal counsel, and other possible differences. The pool of interviewees was representative of a cross-section of physical therapy program directors from large and small, and from public and private, academic institutions. A majority (three of five) of the minority program directors was selected for interview. The interview process spanned the time period between October 2001 and February 2003.

The final twenty interviewees represent maximum possible diversity in gender (ten female; ten male), race, program type (eleven private, nine public; ten large, ten small; eleven

metropolitan, nine non-metropolitan), and geographic locale. They were finally selected based on their availability and their ability and/or willingness to commit to an approximate two-hour in-person interview with the author.

Data Collection

Identifying affinities

Open coding of categories of common meaning was conducted by the author based on his expertise as an attorney and physical therapy education program director, developed over the past twenty-one years. Affinities were validated and piloted with a 3-person focus group, whose members were selected for their physical therapy-related legal and education program administration expertise. The focus group members were: Jonathan Cooperman, JD, PT, President, Ohio Physical Therapy Association; Elizabeth Domholt, Ed.D., P.T. Dean, Krannert School of Physical Therapy, University of Indianapolis; and Herm Treizenberg, Ph.D., P.T., Director, Physical Therapy Department, Central Michigan University.

The following open coding affinities were identified:

- **Complexity** of the legal, practice, and academic macro environments (propensity of people to resort to litigation, number of, and changes to, applicable governing laws and regulations, the professional health education environment as a business)
- Breadth and complexity of specific **legal issues** confronting physical therapy academic

program directors (student admission and dismissal issues, faculty and union issues, clinical affiliation and related contractual agreements)

- **Preparation** for legal dimension of program directors' roles through orientation, continuing education, etc.
- Institutional **barriers to access** to consulting legal counsel (stoic, self-sufficient puritan ethic of administration vis a vis utilizing legal counsel)
- Personal **risks** of utilizing consulting legal counsel (alienation of others, team player)
- Institutional and personal monetary **costs** associated with legal consultations (time, money, out of whose budget?)
- **Reactive vs. proactive** legal consultations (putting out fires vs. systematic planning and selective ad hoc use)
- Impressions of **public perceptions** of the legal system and of attorneys (negative, fiduciary)
- Pre- and post-consultation **personal perceptions** and attitudes of program directors toward consulting legal counsel, and underlying rationale
- **Responsiveness** of legal counsel to program director requests for advice
- **Competence** of consulting legal counsel in addressing physical therapy legal issues
- **Satisfaction** with consultation results and sequelae
- Utilization of **collateral advisors** and counselors, e.g. ombudspersons
- Attributes of the **attorney**-program director-**client relationship** (cordiality, confidentiality)

- Opportunities to **improve** the attorney-physical therapy education program director-client **relationship**
- Opportunities to **improve** attorney-program director consultation **outcomes**

The Interview Process

Interviews took place at a mutually agreeable time after coordination via a cover letter inviting the respondents to take part in the study and the explanation of, and signing of, the informed consent instrument for participation in the study. In-person interviews were carried out in settings as informal as possible (e.g. interviewees' personal office spaces, conferences, home [in one case]), with as few distractions as possible, to maximize openness and minimize distortion within the natural flow of interaction. Five of the twenty interviews were conducted telephonically because of geographical and cost-related constraints.

The interview process in this study utilized a standardized, semi-structured interview instrument to minimize variation in questions and to diminish bias. The instrument and process allowed for spontaneous probing follow-on interviewee-specific questions, as well as the opportunity for summative comments by all interviewees. The process was designed to optimize meaningfulness and impart open, explicit and complete interviewee perspectives.

Types of questions posed included knowledge, experience, opinion/value, and feeling (emotional responses to experiences and thoughts) inquiries (Patton, 1990, pp. 290-292). In the interests of efficiency of time and space and interviewee privacy, non-relevant background and demographic questions were not included. Sensory questions were irrelevant to this study and

were likewise not included.

Questions were sequenced to commence with noncontroversial basic knowledge, skill and relevant background inquiries. Care was taken to ensure that questions were open-ended, neutral, singular and clear. When dichotomous (suggesting "yes" or "no" responses) questions (Patton, 297) were employed, open-ended extender inquiries, such as "Please explain," were appended to the dichotomous ones, so as to avoid converting the interviews into truncated interrogatory quizzes. Later questions transitioned into ones that demanded higher order reflection and responses – analysis, synthesis and evaluation (Bloom, 1956). Examples of evaluation format questions included those asking interviewees for ways to suggest ways to improve attorney-client relations.

"Why" questions, which presuppose the existence of knowable reasons for world events (Patton, 313), were avoided. Neutrality as to interviewee responses was maintained through prefatory statements by the interviewer (an attorney-physical therapist, and known as such by all interviewees) which expressed in advance personal understanding and acceptance of any and all responses related to attorney-client relations and the strong desire on the part of the interviewer for openness and frankness in interviewee responses.

The interviewer was cognizant of the need not only to develop rapport with the interviewees, but also to appear neutral and not bias the process through any of his verbal or nonverbal conduct. Particularly, the interviewer strove to avoid influencing interviewees in their responses with his ethical frameworks or biases concerning the legal system, attorneys and attorney-client relations.

Data were recorded both on tape and in notes. The goal for utilizing both media for

recording was to maximize the likelihood of capturing the exact words and meaning of the interviewees. All interviewees consented to both instrumentalities, and neither appeared intrusive or distracting. Note transcription additionally facilitated the recording of observations about interviewees, the environment, and the interview itself.

Each interview lasted between one and two hours. The interviews were transcribed and coded by the author. The interview instrument appears below.

INTERVIEW PROTOCOL

1. Introduction; review invited participant and study information.

2. Review and reiterate informed consent.

3. Review confidentiality statement and consent to audiotape.

I. LEGAL ENVIRONMENT

1. Many physical therapy professional education program directors comment on the complexity of the legal environment within which they operate. What makes this environment so complex?

A. What factors contribute to the complexity of the legal environment?

B. Are participants in the physical therapy professional education setting litigious? The same, more, or less than the population-at-large?

C. Is physical therapy professional education becoming more businesslike? If so, what factors contribute to this phenomenon?

D. Briefly describe the key laws and regulations affecting physical therapy professional education.

2. Describe the nature of legal issues confronting physical therapy professional education program directors.

A. How many legal issues arise annually in your program (over the past 3 years)?

B. In which general areas? (student, faculty, staff, intellectual property, real property, community relations, accreditation, other)

3. Describe your preparation to address program-related legal issues.

A. Does your institution offer formal and/or informal legal education for academic program directors?

1. If so, have you had the opportunity to take advantage of it?

2. If so, what is your impression of the experience(s)?

B. Do you have any formal or informal outside education and/or training in legalities?

II. ACCESS TO LEGAL COUNSEL

1. Do you have direct access to institutional legal counsel for consultation on program-related legal issues?

2. Are there any institutional barriers to access to consulting legal counsel for program-related

advice?

3. Do you have a personal legal advisor?

A. If so, do you utilize personal legal counsel for program-related legal advice?

4. Do physical therapy professional education program directors incur professional and/or personal risk incident to program-related legal consultations with institution-based legal counsel?

A. If so, what risks are involved in this process?

5. Who bears the monetary cost of program-related legal advice?

III. PERCEPTIONS OF, AND ATTITUDES TOWARD, ATTORNEYS, THE LAW, AND THE LEGAL SYSTEM

1. What are your personal perceptions of, and attitudes toward, the law and the legal system?

A. What factors contribute to these perceptions and attitudes?

2. What are your personal perceptions of, and attitudes toward, attorneys?

A. What factors contribute to these perceptions and attitudes?

IV. THE ATTORNEY-CLIENT PROFESSIONAL RELATIONSHIP

1. Is legal consultation between you and counsel carried out systematically, *ad hoc*, or both?

A. Is it carried out proactively, reactively, or both?

2. How would you describe the attorney-client professional relationship between you and counsel?

A. Is the relationship confidential?

B. Is your legal counsel a fiduciary?

C. When, if ever, may the confidential or fiduciary nature of the relationship be breached?

3. What are your personal perceptions of, and attitudes toward, your consulting legal counsel regarding program-related consultations?

A. Describe the general responsiveness of legal counsel to your needs and requests.

B. Describe the general competence of consulting legal counsel to address physical therapy issues.

C. If applicable, how did your perceptions and attitudes toward counsel change post-consultation experience(s)?

4. Describe your general satisfaction with consulting legal counsel on program-related issues.

A. Is your degree of satisfaction the same or different for the single most important legal consultation over the past 12 months vs. overall? Explain.

B. What factors contribute to your relative satisfaction with consulting legal counsel on program-related issues?

5. What advisors, other than institutional and personal attorneys, are available to you for program-related legal advice?

A. How, if at all, do you utilize them?

B. If you utilize other advisors for program-related legal advice, what is your general satisfaction with their input?

V. OUTCOMES AND IMPROVEMENT

1. How would you characterize outcomes of program-related legal consultations?

2. What factors might improve the outcomes of program-related legal consultations?

3. What additional factors might improve the attorney-client relationship generally?

VI. Conclude by asking respondents if there are additional points they would like to make to complete or clarify their input. Strongly encourage thorough communication of respondents' ideas. Thank them for their participation; give details on follow-up and dissemination of results.

Data Analysis

Affinity Analysis

Post-interviews, axial and theoretical coding ensued. Axial coding entails developing narrower frames of reference (affinities and subaffinities) from the open code affinities. Theoretical coding involves defining, delineating, and displaying the relationships between and among the axial affinities. The precise axial and theoretical affinities are discussed in Chapter 4.

Content analysis involves categorizing primary patterns in the data (Patton, 381). During axial coding, data were coded, labeled and indexed. Inductive analysis was conducted, with patterns and analytical themes derived from the interview data. Indigenous typologies were developed, based on analysis of the cognitive processes observed in the interviews. (Pelto & Pelto, 1978; p. 54). The process of convergence (Lincoln & Guba, 1978) was employed, in which recurring regularities in data were identified, which were further classified as patterns, and then sorted into categories. Patton's utilization-focused approach to data analysis (p. 405) was used to help keep findings practical and from appearing excessively abstract or theoretical.

Internal homogeneity (interrelatedness) and external homogeneity (bright-line divisions among patterns and categories) ensued. Phenomenological reduction or attempted purification of data through identification of key words and phrases and their recurrence preceded horizontalization (spreading out for unbiased examination)(Patton, p. 408) and organization of data into meaningful clusters, from which themes were synthesized structurally during theoretical coding.

Cross-classification matrices were created from the data. Because of observable differences in female and male respondent answers, a comparative analysis of female and male physical therapy program directors' responses was made. These differences are limited to the participants in the study. No inference should be drawn from them about the whole population of physical therapy education program directors.

No comparative analysis of minority physical therapy program directors was developed, however, because of the small number of minority physical therapy program directors (n=five during the period of the study) and the resultant possibility of unintended identification of one or more of them based on their responses to questions in the interviews. There were no observable differences in responses based on program size, public vs. private programs, or geographic locale.

Constructing the Interrelationship Digraph

An interrelationship digraph was developed, using the theoretical coding affinities, to delineate how the various parameters of physical therapy education directors' perceptions and attitudes toward consulting legal counsel interrelate. This digraph and system schematic illustration will be discussed in Results, Chapter 4.

Assumptions Underlying the Study

There were three key assumptions underlying this study. First, it was assumed that

physical therapy education program directors face the kinds and numbers of program-related legal problems, issues, and dilemmas that necessitate interaction with legal counsel. Second, it was assumed that all physical therapy education program directors have direct or indirect access to legal counsel for program-related legal consultations. The range of available legal counsel includes institutional counsel, personal legal counsel, professional association counsel at the state and national levels, and adjunct legal advisors, typically attorney-physical therapist colleagues or informal institutional advisors. Third, it was assumed that focus group members, respondents, and peer reviewers would be candid and comprehensive with their comments and input before, during, and after the interviews.

Chapter 4

Results

Description of the affinities

The following section describes the axial and theoretical affinities of this study. The annotated thick descriptions include a substantial number of seminal respondent comments.

Complexity

Ninety percent (18/20) of respondents perceived the physical therapy education environment to be complex in terms of its legal dimensions. One respondent remarked that "legal language is unfamiliar to lay people. The legal body of knowledge is massive. We don't have the time, inclination or energy to read case law!". Another stated that institutional hierarchal channels of authority, including labor unions, wrest control from the program director, causing the director to have to "explain in different languages what your needs are" to multiple constituencies.

Three respondents viewed graduate students as "customers" or a "diverse clientele who possess a sense of entitlement and engage in self-advocacy," and whose "needs must be satisfied," lest they "threaten [or] bring legal actions against the department." Two respondents find institutional attorneys to be "a big part of the problem, holding up contracts for phrases and

clauses" and "only coming out...when there is a crisis." One respondent finds the state of unpreparedness to deal with the complex legal environment "time-consuming" and "fearful." Another remarked that "admissions recruitment strategies do an end-run around court decisions." Still another lamented "the hell with standards."

Two respondents expressed collective frustration regarding the educational legal environment. "We're not prepared. We are taught how to be teachers. We grade and deal with grade challenges, not for [sic] students asking for disability accommodation." "I can't make decisions based on fear. I'm more self-protective, and that's time consuming."

Two of the 20 interviewees – both female (20 percent of female respondents) – did not find their professional legal environment to be unduly complex. One of them commented "I find that legal things can be seen in a nice straightforward manner. If you understand that fact, it's more facile than the administrative environment generally. Part of it is making sure you've kept up on [sic] any changes that have occurred and have an understanding for [sic] potential liabilities for legal infractions. But once you get into the system, it's a nice, easy straight-line approach, I think."

Litigiousness

Twelve of the 20 respondents (60 percent) were of the opinion that participants in the physical therapy professional education setting are less litigious than the population-at-large. Seven of them (35 percent) believed that physical therapy program participants are as litigious as the general population, and one respondent (five percent) found physical therapy education

program participants to be more litigious than the population-at-large.

The comments of representative interviewees across the spectrum of responses are revealing. Respondents' comments demonstrated their high level of altruism and trust. "In general, we're a group who takes responsibility and seeks to solve our own problems vs. going to legal counsel." "There are many things that students and faculty could sue over, but do not." "We don't want to get sued, or to sue."

As with most other areas in the study, there was a difference noted between the responses of female and male physical therapy program directors regarding the issue of litigiousness. Twice as many female physical therapy program directors (eight of ten, or 80 percent) believed that physical therapy education program participants are less litigious than the population-at-large, while only four male directors (40 percent) believed that to be true. Five (50 percent) of male respondents believed that physical therapy education program participants are as litigious as the general population, while only two (20 percent) female respondents so believed. One male interviewee (10 percent of male respondents) felt that physical therapy graduate institution personnel are more litigious than the population-at-large, in part because "graduate institutions are anxious to avoid lawsuits, so they funnel everything through counsel. We're 'gun-shy'."

Numbers and types of legal actions

All respondent-physical therapy education program directors had experienced adverse legal actions against them and/or their programs. Thirty percent (six of 20) of them experienced less than one legal action per year, on average. Forty percent (eight of 20) were involved in one

legal action per year. Ten percent (two of 20) per grouping experienced: two or three, four or five, and more than five adverse legal actions per year.

Types of legal actions experienced reportedly involved the following areas: accreditation, clinical contracts, faculty, intellectual property, and students. No other classifications of legal actions, such as real property cases or cases involving the community external to the college or university, were reported. Student issues giving rise to legal action included: academic admission and dismissal, accreditation status of the academic program, civil rights issues involving student HIV status, and interpretation of rights contained in the student handbook. Faculty legal cases involved: adjunct faculty rights, firing, hiring, intellectual property (patent), interpretation of rights contained in the faculty handbook, tenure, and worker's compensation for job-related injuries or illness.

Across the spectrum of legal actions, female physical therapy education program directors experienced fewer causes of action than did their male counterparts. Five of ten (50 percent) of female physical therapy education program directors faced fewer than one legal action per year compared to only one of ten (ten percent) of male respondents. Three female respondents (30 percent) experienced one legal action per year, compared to five male directors (50 percent). One male and one female physical therapy education program director (ten percent of each group) reported having either: two to three, or four to five, legal actions per year, each. Two male respondents (20 percent of total) experienced more than five legal actions per year, while no female interviewees experienced more than five legal actions annually.

Legal education

Because knowledge of the law as it relates to graduate professional education program administration is deemed to be critically important, interviewees were queried about their preparation to address program-related issues. Two types of legal education were inquired about – that offered within respondents' respective academic institutions specifically for academic program directors, and that obtained outside of the academic institutions in which respondents were directors.

Five of 20 respondents (25 percent of total) reported having received formal or informal legal education within their respective academic institutions, specifically targeted at academic program directors. For one of them, that institutional offering consisted of a triennial professional development seminar for academic program directors, which was "principally procedural vs. substantive in nature." Another said that institutional legal education is exclusively *ad hoc,* offered by legal counsel during individual consultations. Still another respondent said that legal counsel briefly addressed new academic program directors during an initial orientation session. For another, legal issues were touched on during an annual leadership retreat for chairs. Finally, one respondent from a large academic health center reported that a well-developed annual formal legal training program is in place within the institution, addressing current case law, disability awareness, sexual harassment, and other discrimination issues. Attendance by academic program chairs was mandatory for these training sessions. "We call on legal counsel to educate us, more than to advocate."

In contrast to the relative small number of respondents who experienced institutional

legal education and training, nine of 20 respondents (45 percent) reported having experienced legal education external to their employment settings. One respondent took a contract law course during active duty military service. Another was trained as a hospital manager. "I know just enough to be dangerous. I'd love to know more." Two more respondents undertook higher education law courses during doctoral studies, and one each took a public law and a health care administrative law course. Another admitted to perusing legal textbooks. One took three law courses in graduate school – in business, health, and higher education law. Still another had previously been a state-licensed health care risk manager with vast legal education exceeding 120 contact hours. Finally, one respondent regularly attended continuing legal education courses sponsored by the American Association of Higher Education and other entities.

Of those respondents experiencing no legal education or training, their responses were noteworthy. "I just fly by the seat of my pants." "I just pick my way through." "It's easier to seek forgiveness than to ask permission." "School of hard knocks." "First-hand experience only." "The university hates us."

Female respondents reported receiving more legal education and training than did male respondents. Four females (40 percent of women) received institutional-based legal education, compared to one male respondent (ten percent of men). Six of ten female respondents (60 percent) undertook legal education and training outside their academic institutions, compared to three male respondents (30 percent).

Knowledge of the law

Respondents were queried about their knowledge of laws affecting the administration of graduate physical therapy education programs. Respondents were asked to name or describe key laws and regulations. Any reasonable answer – an administrative regulation, a case name, a state or federal constitutional law provision, a statute, or otherwise – was deemed acceptable among possible choices.

Seven of 20 respondents (35 percent) enunciated a law affecting physical therapy education by name, number, or category. No one expressed any depth of knowledge about relevant laws or regulations affecting physical therapy education. Responses included "the state physical therapy practice act," "Statute 90210 [not accepted, because of its apparent reference to a current popular television program]," "the ADA [Americans with Disabilities Act of 1990]," "FERPA [Federal Education Rights and Privacy Act]," "Buckholder (sic) amendment [Buckley amendment]," and "Stark." One respondent hinted at FERPA by saying "I know that parents get bent out of shape because we don't freely share information with them." Another respondent addressing FERPA admitted "I've broken confidentiality on occasion." Still another volunteered "I copiously violate it [FERPA] – individually and collectively." Finally, one respondent identified a federal administrative agency by saying that "CAPTE [the Commission on Accreditation in Physical Therapy Education] functions using guidelines from the Department of Education [a federal administrative agency]."

Four female respondents (40 percent) and three male respondents (30 percent) enunciated a rudimentary knowledge of the law as it related to physical therapy professional education.

Direct access to institutional legal counsel

Respondents were asked whether, as professional education program chairs, they had direct (unfettered) access to institutional legal counsel for consultation on program-related legal issues. Eleven respondents (55 percent) enjoyed direct access to institutional legal counsel.

One respondent stated "I have the right to do it because of my seniority. I never have, though. Normally, I go through the dean or the university ombudsman." Another said "I don't ask permission. I just do it." Still another asserted "The dean encourages it." Two respondents have personal relationships with institutional legal counsel, facilitating direct access. "Direct in the sense that I know her well. I just call her any time." "Our daughters play together, so I could call her – but I don't."

Those respondents without direct access to institutional legal counsel typically required permission from their deans, ombudspersons, vice presidents for administration or academic affairs, assistants to presidents, provosts, or other "senior administration officials." One respondent described the process of seeking permission to consult with legal counsel on program-related issues as "a filtering mechanism, not a stop-gate." Another remarked that "The layers of hierarchy that you have to go through make it complex. Items go through the provost and dean's office for legal signature. It takes weeks to get anything done." Another said, "The School of Medicine treats us like a bastard child. I follow the philosophy of keeping the chain of command, i.e. the dean, apprized."

There was a substantial difference between female and male respondents in terms of

direct access to institutional legal counsel for advice. While seven of ten female respondents (70 percent) have direct access to legal counsel (including both female respondents having personal relationships with counsel), only four of ten (40 percent) of male respondents had direct access to their institutional attorneys.

Institutional barriers to utilization of legal counsel for advice

If education program directors perceive that there are institutional barriers to their utilization of legal counsel for program-related advice, then that perception is likely to have a chilling effect on such consultation. In this investigation, a majority of respondents – twelve of 20 (60 percent) – perceived the existence of institutional barriers to their free utilization of legal counsel.

One respondent remarked that "Because I don't have direct access to legal counsel, I can only guess as to whether my communications are accurately conveyed to counsel through the administration." Another bypassed the administrative system in place entirely. "There probably are [barriers]. I don't use channels, though. I just say, 'I'm new here.'" Several respondents reported that legal counsel as an entity in and of itself constituted a barrier to communication. "The lawyers want a long-version contract for everything. The paperwork and delays are long. We need a standardized contract that they [counsel] don't have to sign." According to another, "Counsel won't talk to me because she's mad at me. On one occasion, staff counsel forgot to prepare me for a deposition." Still another attributed the high turnover in legal staff within the institution as a barrier to utilization of counsel. "It's a revolving door. I've worked with five or

six lawyers already. In their defense, it is boring to review contracts, plus they are not well paid."

Another respondent found the dean's office staff, but not the dean, to be a barrier to utilization of counsel. "They want prior coordination on everything I do. They sometimes get bent out of shape when I consult with legal counsel without their knowledge." Still another considered the dean and legal counsel to jointly constitute a barrier to legal consultation. "The dean has to agree that it's worth it. I have to work hard to convince the dean of its need. I've never physically met counsel. It's always been over the phone."

Seven of ten (70 percent) of male respondents perceived institutional barriers to utilization of legal counsel for program advice, while three of ten (30 percent) of males did not. For female respondents, five of ten (50 percent) perceived such a barrier, and five (50 percent) did not.

Monetary costs of program-related legal advice

The assignment by an institution of higher education of a cost center for program-specific legal consultations may influence the perceived value of such consultations on the part of education program administrators. The allocation of costs for legal consultation to department-level budgets may also further inhibit utilization of legal counsel. In this study, 17 of 20 respondents (85 percent) reported that the costs of institutional legal consultations were borne centrally by the respective institutions. Only two respondents – one female and one male (10 percent of each group) – had such costs allocated to their individual academic departmental

budgets. One (female) respondent believed (incorrectly) that there were no costs at all associated with the utilization of institutional legal counsel.

Personal legal advisors

The existence and utilization of personal legal advisors for program-related advice may be important to those respondents who do not have direct access to institutional legal counsel and to those who perceive substantial internal barriers to free access to institutional legal counsel. In the present study, eleven of 20 respondents (55 percent) had personal attorneys [six males (60 percent of males) and five females (50 percent of females)].

Only one (female) respondent utilized her personal attorney (also a family member) for program-related advice. Of those respondents with personal attorneys who did not utilize them for program-related advice, one remarked, "Hypothetically, would I? Yes, if I have to step down as program director. I would use my own lawyer to negotiate severance pay." Another added "If I thought that my personal rights were in jeopardy, I would." [Neither of these scenarios involved program-related advice.]

Personal risks incident to legal consultation

Like institutional barriers and monetary costs, personal risks to employment, professional reputation, or other attribute, for seeking legal advice for program-related issues may have a chilling effect on utilization of institutional counsel. In this study, six of 20 respondents (30

percent) believed that there may exist personal risks incident to legal consultations. One said (laughing), "Most definitely. I learned to be careful about information. I may need my own attorney." One other remarked "If I sought legal counsel's advice, it would cause great displeasure to the administration, and I would not be thought of as a team player." Another said, "I wouldn't be surprised if the dean threatened my job security. So what!" Still another said "I don't know. Our concerns have been mutual and congruent thus far."

One respondent seemed to defend sanctions against program directors who utilize legal counsel frequently. "In the case of a program where the chair constantly and inappropriately seeks legal advice, such a person is suspect." One respondent believed that failing to appropriately seek legal advice from counsel might put a program director at risk. "We had one instance last year when we had a piece of information about a student and did not want to talk to a lawyer about it, so we didn't call. I may have put myself professionally at risk."

The comments of two respondents who did not sense any personal risk for seeking legal consultation were also interesting. One noted, "Quite the opposite. [The] administration wants you to be prudent. No such thing as a dumb question." The other defended both the right of the administration to limit legal consultations and the right of the chair to go forward when necessary. "No risk. The dean would put a stop to it if it were excessive. If I felt it was still necessary, then we would get into loggerheads."

Twice as many female as male respondents – four of ten (40 percent) vs. two of ten (20 percent) – believed that legal consultation for program-related issues was potentially risky for physical therapy education program directors.

Respondents' opinion of the law, legal system, and attorneys

As doctorally-prepared education professionals, it is expected that respondents' opinions about the law, legal system, and attorneys might be more articulate, rational, and reserved than those of the public-at-large. Nine of 20 (45 percent) respondents had positive personal opinions of the law and legal system. Thirteen of 20 respondents (65 percent) had positive personal opinions of attorneys.

On the positive side, the following comments were presented. "It is a good guarantor of legal rights and protector of individual privacy." "You can work within the system to effect positive change." "Legal theory – it's fascinating. The idea of taking highly emotional circumstances and trying to find rational ways to deal with them is interesting." "I respect the system."

Those respondents with negative opinions about the law and legal system commented as follows. "The system is flawed." "The system is broke, biased." "It depends on a person's resources. If he has money, it's great. "People see getting injured as hitting the lottery." "You don't ever want to end up in court. It's a terrible place where terrible things happen."

One respondent's negative opinion about the legal system was based on experiences as a juror. "I was on two juries. I was a bit disillusioned about what we didn't know or weren't told about the facts. Juries can easily misunderstand judicial charges to them."

Seven of ten female respondents (70 percent) had a positive personal opinion about the law and legal system. Two of ten male respondents (20 percent) had the same positive opinion of the legal system.

Favorable comments included the following. "If you need one, you've got to have one. I have a high opinion of the ones I've consulted with." "I've learned a lot from them over the last ten years." "More of them act as mediators than advocates per se. They are the experts." "The lawyers I know privately are all hardworking, committed, intelligent human beings." "Most attorneys are fair and seek to do the right thing. If a relationship with a client interferes, they don't see that client." "I was very positively affected by the lawyer who taught my administrative law course. He is a wonderful role model. I want our students to partner with that kind of lawyer." "The adversarial nature of their relationships is difficult to comprehend from our health care professional-patient perspective." "I look at them positively and give them the benefit of the doubt – instantly." "I have a lot of friends who are lawyers. They are good people. They do what they are educated to do. There are good people in every profession, and there are unethical ones. Lawyers are no different."

The negative comments about attorneys expressed by some respondents are revealing of deeply-held opinions and biases, which are often experience-based. "I'm cautious with lawyers, like I am with doctors. There are good and bad ones. I ask for referrals." "In high-profile cases, lawyers seem to stretch personal ethics. Right and wrong are unimportant to them. The operative question is, 'What can I get away with?'." "Our lawyers overplay the protective role to enhance their own importance." "Lawyers suppress creativity and communication." "You get what you pay for. Don't tell me if it's ethical. Just tell me it's legal." "Through my expert witness work, it's interesting to see the theater part of it. 'I don't like your answer, therefore, I go through heavy non-verbal cues to show that I'm displeased.'" "Some lawyers have the goal of making 'X' million dollars by a certain age. But I don't pigeonhole individuals."

Eight of ten females (80 percent) expressed positive opinions of attorneys. Five of ten male respondents (50 percent) also expressed positive personal opinions of lawyers.

Systematic vs. ad hoc advice

Systematic legal consultation between physical therapy graduate education program directors and their attorneys involves that consultation that is preplanned and regularized, compared to *ad hoc* consultation, which is event-driven. No respondent in this study believes that his or her consultations with institutional legal counsel on program-related issues were exclusively systematic, as defined above. Sixteen of twenty respondents (80 percent) believed that legal consultations were exclusively *ad hoc* in nature. Four respondents (20 percent of total) considered their consultations with institutional legal counsel to be of mix of systematic and *ad hoc* encounters.

Respondent comments hint at a sense of frustration with the process. "Systematic for clinical contracts; *ad hoc* for all else. "One patent issue handled systematically; the rest "off-the-cuff." "*Ad hoc*. I always initiate the discussion. "Always on a p.r.n. [as-needed] basis. They never come to us." "Not systematic – no regular appointments. On a need basis." "*Ad hoc* – no systemic interaction." "Regarding clinical contracts, the university's counsel doesn't even want to review them." "Both. Systematic in the sense that we meet at certain times, and things move from one step to another. Usually via email. *Ad hoc* in the sense that if there's a situation I want handled in a certain way, I discuss it with the lawyer, but only after getting the dean's permission."

For nine of ten male respondents (90 percent) and seven of ten female respondents (seventy percent), program-related institutional legal consultations were exclusively *ad hoc.* For one male respondent (ten percent of males) and three female respondents (30 percent of females), consultations were a mix of systematic and *ad hoc* meetings.

Proactive vs. reactive consultations

Proactive legal consultations between physical therapy graduate education program directors and their attorneys take place in anticipation of, rather than as a reaction to, a legal problem, issue, or dilemma. Reactive consultations occur after such events have already arisen, and legal attention is necessary.

One of 20 respondents (five percent) reported exclusively proactive consultations with legal counsel on program-related issues. Five of 20 respondents (25 percent) reported exclusively reactive legal consultations. Fourteen of 20 (seventy percent of respondents) experienced both proactive and reactive consultations with institutional legal counsel.

For most respondents, proactive legal consultation was confined to review of clinical affiliation agreements and other contracts. "Proactive for contracts; reactive for everything else." For some others, however, most consultations were proactive in nature. "Mostly proactive. We check with them before making any move. I was told when I got here, 'You're turned loose. Stay out of trouble." "I went proactively to the administration and counsel on sexual harassment and student issues because I found nothing in place in the university publications." "Both. Preferably proactive, but I'm not that smart." "I rewrote our academic

standards today. They'll be reviewed by counsel. That's proactive." "Both, but always at my prompting. The deans have proactive consultations with counsel, and the information is channeled to us." "It starts out proactive. It turns reactive. Contracts get done at the last minute." "Always reactive regarding student issues."

One male respondent (ten percent) reported that legal consultations on program-related issues were exclusively proactive. No female respondent reported legal consultations to be exclusively proactive. Three of ten male respondents (30 percent) and two of ten female respondents (20 percent) had exclusively reactive consultations with legal counsel. Six of ten males (60 percent) and eight of ten females (80 percent) experienced both proactive and reactive consultations with legal counsel on program-related issues.

Attorney-client relations

The nature of the attorney-client relationship is a confidential, legally-privileged relationship in which the attorney acts as a fiduciary , or person in a special position of trust for the client. A *fiduciary* is a person who exercises fidelity and good faith and places a beneficiary's interests (here, the legal client) above all others – including the fiduciary's own personal interests, except when those interests perpetrate a fraud or otherwise violate an attorney's duty as an officer of the court (*Black's,* 1979, p. 564).

The degree of confidentiality between attorney and client is of the highest level of any interpersonal relationship. Its legally privileged status is designed to promote the free exchange of information from client to his or her attorney. An attorney is not free to share with third

parties information conveyed by a client, unless such information involves the perpetration of a future crime that entails serious bodily harm or death or constitutes a clear and present danger to national security. No other confidential relationship – even the clergy-penitent relationship – imposes so high a fiduciary duty upon a professional as does the attorney-client relationship.

Confidentiality

Twelve of 20 respondents (60 percent) considered their relationships with institutional legal counsel to be confidential ones. Seven of ten male respondents (70 percent) and five of ten (50 percent) of female respondents made up this group.

Respondent comments reflected a sense of uncertainty about the existence and extent of confidentiality in their relationships with legal counsel. "Yes, I have the feeling that it is confidential." "I've taken it on faith that the attorneys are holding my communications in confidence." "I assume it is." "I believe it's confidential. Maybe I'm naive." "I wouldn't take a sexual harassment case against me to them."

All five female respondents who did not believe that their relationships with institutional legal counsel were confidential were adamant in their beliefs. "I don't expect the college's counsel to represent me personally. I'm not the client." "I don't consider myself to be the client. If I've done something jackass, he can report me to the administration." "The institutional counsel would not respect my confidentiality." "Definitely not! Everything I say goes straight to the dean's office." "They have to let the administration know what I say."

Fiduciary

Twelve of 20 respondents believed that their institutional legal counsel were their fiduciaries, that is, that counsel were bound by law to place respondents' interests above all others. Twice as many male respondents – eight of ten (80 percent), as females – four of ten (40 percent), considered their relationships with institutional counsel as fiduciary attorney-client relationships.

Several respondents said they conditioned their sharing of confidential information with counsel on the understanding that counsel were acting as fiduciaries. "If that changed, I'd end the relationship." "It's either absolute or not." One female respondent asserted, "I'm quite confident with my personal attorney as a fiduciary, but not institutional counsel."

Two other female respondents clarified for whom institutional counsel was a fiduciary. "The university's best interests." "I'm just an officer of the institution."

At least one respondent required a definition for "fiduciary." The definition above was offered only when solicited.

Breach of confidentiality

Thirteen of 20 respondents (65 percent) expressed knowing when confidentiality may be breached by institutional attorneys rendering program-related advice. Nine of ten female respondents (90 percent) and four of ten male respondents (40 percent) were included in this group.

Sample male respondent responses of those not knowing when confidentiality might be breached included the following. "I don't know. We're state employees. If we're acting within scope, they won't breach it." "When the individual's interests diverge from those of the institution. 'Cut and run.'"

Male respondents with rudimentary knowledge of when confidentiality might be breached expressed the following comments. "If I pose a direct threat of serious harm to others. It's a matter of judgment." "If there's criminal conduct, it may be breached."

Female respondent comments were particularly cogent, since many of them professed *ab initio* that there was no legal confidential relationship between counsel and education program directors, only between counsel and the institution. Comments included, "Since I'm not the client, if counsel heard something adverse to the university, they would have to ask the official to stop there and seek personal counsel." "I only say what I want communicated."

One female respondent incorrectly asserted that "I don't think they ever could without my permission."

Responsiveness

Respondents were nearly evenly divided over legal counsels' responsiveness to their needs. Nine of 20 respondents (45 percent) considered their legal counsel generally responsive; eleven of twenty (55 percent) did not. Five female respondents (50 percent) and four male respondents (40 percent) considered their legal counsel generally responsive to their needs.

Negative comments expressed strong displeasure with counsel. "Not so good with

mundane stuff." "Not good with contracts." "I had one case last summer and counsel never got back to me." "Not quick enough. We've forced improvements though." "They're slow. You have to wait a long time for responses. It's not high on their priority list."

The following were representative positive comments. "Great. Their advice is sound. They really seem to understand the academic enterprise and support us." "High. I can get an answer from a lawyer or paralegal within four hours. The paralegals are good" "Excellent – especially the AG [attorney general]." "I expect it."

Competence

Thirteen of 20 respondents (65 percent) rated their legal counsel as competent; seven of twenty (35 percent) did not. Seven male respondents (70 percent) and six female respondents (60 percent) rated their legal counsel as competent.

Positive comments were as follows. "Thoroughly professional." "My perception of the competent attorney was confirmed." "Excellent. Our lawyers have many years of longevity." "High. I've never doubted their ability with legal issues." "Excellent. He knows the rules and regulations." "Appears competent, but I'm not her peer." "The legal department is one of our real strengths. I wouldn't say that about all support divisions." "Universally impressed – very open and easy to talk to."

Negative comments were revealing as well. "They tend not to give us concrete answers. You're still left with being the decision maker, instead of them giving you the answer." "I think I could do it as well as the lawyer." "It [advice] seems emotional. It's inconsistent. I don't feel

comfortable that we get good advice from our counsel."

General satisfaction with counsel

Twelve of 20 respondents (60 percent) expressed general satisfaction with their consulting legal counsel. Eight of 20 (40 percent) did not. Seventy percent of male respondents (seven of ten) were generally satisfied with counsel, while fifty percent (five of ten) females shared this view.

Positive comments relative to factors contributing to respondents' general satisfaction follow. "The attorney listens well and asks good clarifying questions, which is characteristic of lawyers in general. Advice is concrete and usable, and hits the problem." "They help by suggesting wording or courses of action. They give advice over the phone." "Educative. Confirms that we're handling things the right way." "The lawyer took a lot of time to gather important facts." "Counsel's honesty and respect for the urgency of situations. Her adeptness of working with people." "They're able to give me advice that's doable and fair. Not in legalese. If they start to use terms I don't understand, they break it down." "They seem to quickly understand 'the real issue.' They can take someone who's not a lawyer; listen to a scenario; put it in legal terms; and translate advice in the form of an answer in lay terms. The university is very conservative and fearful of lawsuits. The lawyer's advice is less restrictive. This helps to advocate a more liberal position."

Negative satisfaction comments ranged from concise to confusing. "We streamline everything to make their jobs easier. We check off what action we need. It takes months

sometimes. Sometimes I call over and over. 'Hi. It's me. Where's my contract?'." "Some shit's not winnable. You just minimize the carnage." "I know my place in the food chain. I have access to Caesar's attorney, the Medical School dean. I don't always get head-of-the-line privileges."

Other advisors

Seven of 20 respondents (35 percent) utilized outside consultants other than institutional and personal attorneys for program-related legal advice. Thirteen of 20 (65 percent) did not. Thirty percent of male respondents (three of ten) and forty percent (four of ten) females used outside advisors for program-related advise.

Outside advisors included for males: the American Physical Therapy Association's general counsel, physical therapist-attorneys, other academic program directors within their institutions, other physical therapist program directors, state and federal public attorneys, and state chapter attorneys. For females, outside advisors included: the American Physical Therapy Association's general counsel and specialty section personnel, human resource management professionals within and outside their institutions, physical therapist-attorneys, other academic program directors within their institutions, and other physical therapist program directors, and state chapter attorneys.

General satisfaction with outside advisors

Five of seven respondents (71 percent) who used outside advisors expressed general satisfaction with their program-related legal advice. One male and one female respondent expressed relative dissatisfaction with outside counsel for program-related legal advice.

Negative comments were as follows. "I lost a case because of a state attorney's incompetence." "I'm not as satisfied [with my institutional outside adviser]. He [alternate counsel within the institution] follows the very conservative approach of the university."

Consultation outcomes

Fourteen of 20 respondents (70 percent) characterized outcomes of program-related legal consultations as positive. Eight of ten female respondents (80 percent) and six of ten males (60 percent) characterized these outcomes as positive.

"Universally high." "Always positive." "I feel protected." "[The cases] go away." "Rational standards are upheld." "They affirm our beliefs." "I'm not always happy losing a student, but I'm pleased that at least we did it the right way." "Don't use one of the six bullets in your gun unless it's absolutely necessary."

The following were representative negative comments of the six respondents not satisfied with legal consultation outcomes. "Curb your dog there! This isn't a major deal, just a clinical education contract [possibly indicating displeasure with overzealous counsel]." "Do lawyers facilitate results, or prevent me from doing things? Ha, ha."

Outcomes improvement

Eighteen of 20 respondents (90 percent; ten of ten females and eight of ten males) believed that program-related legal consultative outcomes could be improved.

Seven of 20 respondents (35 percent; four females [40 percent of females] and three males [30 percent of males]) recommended effective legal education to improve consultation outcomes. Supportive comments were as follows. "Formal education at the beginning, including on the role of counsel." "Ongoing orientation and presentations [by counsel]." "Once a month, with case presentations."

One female respondent found legal counsel ignorant of physical therapy issues. "I spend substantial time educating the attorney on the physical therapy environment."

Another female respondent believed that "[o]nly experience educates us. Learning the hard way. It's an art – how to be diplomatic."

Still another female respondent wanted more legal counsel on the payroll. "More labor down there. It's too small a staff." Another believed that "[b]roader availability of legal counsel would be helpful."

A male respondent found "too much feet dragging" on the part of legal counsel. Another male respondent wanted "clinical sites to be more flexible."

One male respondent reiterated the desire of eight of the nine respondents not having direct access to institutional legal counsel for it. "I would not have to be guessing about whether my situation is being interpreted correctly." One female respondent without direct access to

counsel did not want it, but seemingly proffered mixed signals. "I think we go to counsel less frequently than advisable. I'm not advocating direct access."

Improvement of attorney-client relations

Nine of 20 respondents (45 percent) recommended changes to improve attorney-client relations between legal counsel and physical therapy education program directors. Seven of ten female respondents (70 percent) and two of ten males (20 percent) recommended changes to better the relationship.

"Pay more attention to what people are saying, instead of being condescending." Engage in contract review." "Getting to know each other. It's so dependent on the people involved. They must support each other." "Instilling a feeling of confidence. We just decide non-critical issues on our own." "Better accessibility. I sometimes have to call again." "Try to find middle ground and satisfice all parties."

Miscellaneous comments

Eight of ten female respondents (80 percent) offered additional comments. "It's not a hot-button issue for me. It becomes one only when my butt's exposed." "We shouldn't let fear of lawsuits guide us so much in this country." "I don't want to negotiate with clinics' counsel myself on contracts. I don't want to be a lawyer." "Conservative administrators fear that students will sue. Because of that, they may disregard my advice and that of the lawyers." "I

sometimes feel sorry for lawyers."

Four of ten male respondents (40 percent) offered additional input. "Legal education should be made mandatory for all physical therapy education program directors as an accreditation requirement." "Break the administration's choke-hold on the process." "A lot of my colleagues want to avoid talking to lawyers. I'm an oddball. I want interaction with lawyers to be clear and concise. I'm trying to understand." An opposite comment was that "I'm grateful that I've not had to have extensive contact with lawyers over the program, or lawsuits."

Differences between female vs. male responses

There were differences, ranging from subtle to significant, between female and male interviewee responses for most of the affinities. These differences – among only twenty respondents (approximately one-tenth of the 201-person total physical therapy program director population) – should not be taken as representative of that population as a whole.

Females in this study generally saw the educational legal environment as less complex, and physical therapy education program participants as less litigious than the population-at-large. They also experienced fewer legal actions than their male counterparts, and received more institutional and external legal education than males.

Female respondents reported a greater degree of direct access to institutional legal counsel than did male respondents. They perceived fewer barriers to access to institutional counsel, although they also perceived greater personal career risks from utilizing institutional legal counsel for advice.

Females in the study viewed the law, legal system, and attorneys in a more favorable light than did male interviewees. Their legal consultations were slightly more often systematic vs. *ad hoc,* and were more likely to be both proactive and reactive in nature than those of their male counterparts.

Female respondents were less likely than males to view their institutional attorney-client relationships as confidential, and to see institutional legal counsel as fiduciaries. They were more aware of when the attorney-client relationship may be breached by counsel. Females were generally less satisfied with their institutional attorneys than males, but more often believed that consultative outcomes were positive than do males. They were less likely than males to turn to fellow physical therapy education program directors for legal advice.

Female and male respondents in this study responded similarly in several (mostly procedural vs. substantive) key areas. Both groups displayed only rudimentary knowledge of key laws affecting physical therapy education. For both groups, costs of legal consultations were centralized within their respective academic institutions. Similar numbers of males and females had personal attorneys, and considered their attorneys responsive to their needs and competent.

Equal numbers of male and female respondents utilized physical therapist-attorney colleagues for legal advice. Males and females equally saw a need for improved legal education for program directors in order to improve legal consultative outcomes.

Interrelationship Digraph Matrix and Discussion

Post-interviews, axial coding through narrowing of frames of reference from open coding affinities led to the following axial affinities for the study: barriers to access to counsel;

competence of counsel; complexity of the legal environment; confidentiality/breach in the attorney-client relationship; costs of consultations; direct access to counsel; the fiduciary role of counsel; legal education; legal knowledge; litigation; litigiousness; proactive-systematic vs. *reactive-ad hoc* advice; respondent opinions of the law, legal system, and attorneys; responsiveness of counsel; risks to respondents for seeking legal advice; satisfaction with counsel; and satisfaction with outcomes.

Axial affinities were then further narrowed into theoretical affinities, based on finding relational patterns between and among the axial affinities, as described in the parentheticals accompanying each consolidated theoretical affinity. The eight theoretical affinities are delineated below.

- ***Legal milieu*** (comprising complexity, litigiousness, and litigation);
- ***Access to counsel*** (comprising direct access, barriers, risks, and costs);
- ***Nature of legal advice*** (comprising proactive-systematic and reactive-*ad hoc* advice);
- ***Knowledge of the law*** (comprising education and knowledge of key laws);
- ***Attorney-client relations*** (comprising confidentiality/breach, competence, fiduciary, and responsiveness of counsel);
- ***Satisfaction with outcomes***;
- ***Respondents' perceptions of the law, legal system, and attorneys***; and
- ***Satisfaction with counsel.***

An interrelationship digraph was developed to ascertain relationships between and among

the *eight theoretical* affinities. First, an interrelationship digraph matrix was created. The eight theoretical affinities were arranged along the x- and y-axes. Arrows show the logical relationships between each column and row cell, as follows: (>) indicates that the theoretical affinity in the (horizontal) row primarily influenced the affinity in the (vertical) column, and (<) indicates that the theoretical affinity in the (horizontal) row was primarily influenced by the affinity in the (vertical) column. The sum of (>) and (<) arrows indicates whether each theoretical affinity was, on balance, a primary or mediating system input (driver), or a primary or mediating system outcome, depending on each affinity's degree of positivity or negativity.

Consistency must be maintained between and among rows and columns. That is, if one affinity influenced another (i.e. is an input or "out"(ward) influencer), it must have influenced the target affinity in both row and column entries. The explanation for the directional flow of influences in the matrix and system, based principally on respondents' interview input and secondarily on the author's personal expertise in the area, is described in the next section.

The interrelationship digraph matrix for this study is presented below.

Table 4-2: Interrelationship Digraph Matrix, Perceptions and Attitudes Toward Counsel

Key: LM=legal milieu, AC=access to counsel, NA=nature of legal advice, KL=knowledge of the law, AR=attorney-client relations, SO=satisfaction with outcomes, RP=respondent perceptions of the law, legal system, and attorneys, SC=satisfaction with counsel; >=row influences column, <=column influences row.

	LM	AC	NA	KL	AR	SO	RP	SC	OUT	IN	O-I
LM	--	>	>	>	>	<	>	>	6	1	5
AC	<	--	>	>	>	>	>	>	6	1	5
NA	<	<	--	>	>	>	>	>	5	2	3
KL	<	<	<	--	>	>	>	>	4	3	1
AR	<	<	<	<	--	>	>	>	3	4	-1
SO	>	<	<	<	<	--	>	>	3	4	-1
RP	<	<	<	<	<	<	--	>	1	6	-5
SC	<	<	<	<	<	<	<	--	0	7	-7

The primary drivers (system inputs, or "outs" [strong outward influencers]) included the legal milieu and access to legal counsel. Mediating (secondary) drivers (inputs) included the nature of legal advice and knowledge of the law. Mediating outcomes included attorney-client relations and satisfaction with consultative outcomes. Primary outcomes ("ins" [strongly

influenced from without]) included respondent perceptions of the law, legal system, and attorneys and satisfaction with counsel.

System Schematic and Discussion

The system model for attitudes and perceptions of physical therapy education program directors toward consulting legal counsel was comprised of the eight system variables, arranged in three functional categories (from left to right) – major system inputs, mediators (drivers and outcomes), and major system outcomes. The system schematic represented below displays the flow diagram of interactive influences within the model.

The following paragraphs describe the relevance of the system variables; their functions within the respective categories; direct (left-to-right) inter-variable relationships from category to category; recursive or retrograde (right-to-left) variable interrelationships, if any; and existing external and suggested feedback loops that should operate to optimize system efficacy.

The two major system drivers or inputs were the legal milieu and access to counsel. As primary drivers, these two variables were adjudged by the author to exert the greatest influence on the others in the system. Although they had the same numerical value (+5), the legal milieu was determined by the author to be the more powerful driver, because it directly and logically influenced respondents' access to legal counsel.

Both primary drivers exerted direct influence on both of the mediating or secondary drivers (inputs) – the nature of legal advice and knowledge of the law. The nature of legal advice, in turn, was a weak influencer of respondents' knowledge of the law. (This was decided

by the author based on the fact that at least one respondent reported that legal consultations were educative in nature.)

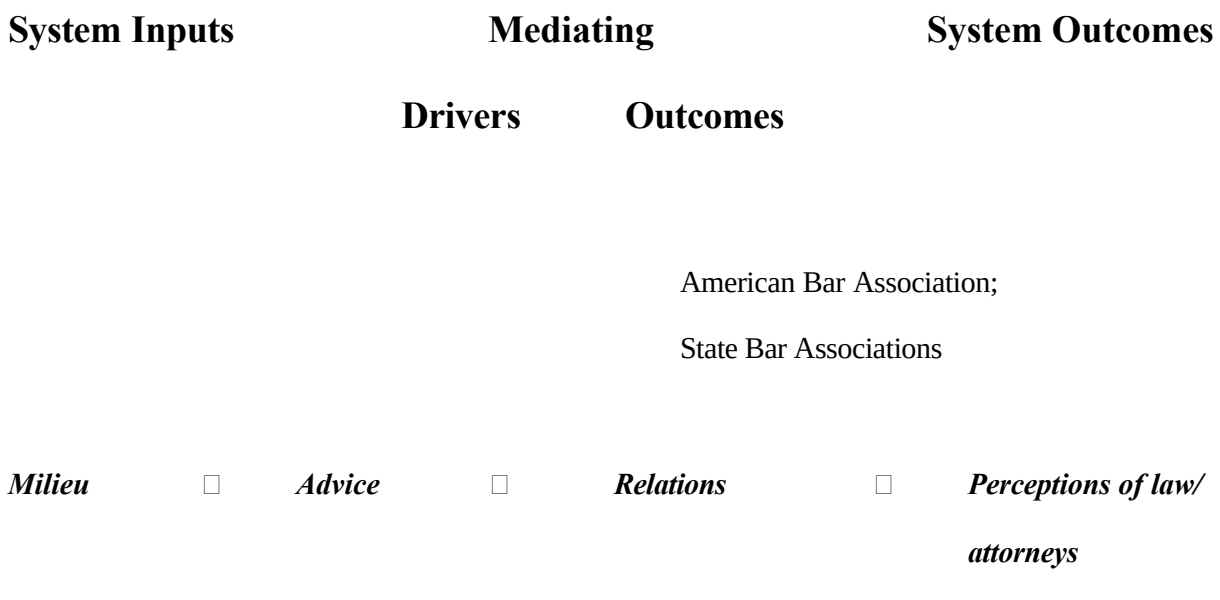
The two mediating drivers, in turn, exerted direct influence on both of the two mediating outcomes – attorney-client relations and respondents' satisfaction with consultative outcomes. Logically, one mediating outcome – attorney-client relations – influenced the other – satisfaction with outcomes, since the manner in which counsel and respondents interacted directly affected respondents' satisfaction with consultative outcomes.

In chain-like fashion (moving from left to right, as before), the two mediating outcomes directly influenced both major system outcomes – respondents' perceptions of the law, legal system, and attorneys, and respondents' satisfaction with counsel. The weaker major system outcome – respondents' perceptions of the law, the legal system, and attorneys – logically influenced respondents' subjective satisfaction with counsel.

There were no apparent recursive or retrograde (right-to-left) interrelationships among theoretical affinities in this system. The system was deemed to be an open systems model in that there were external feedback mechanisms that influenced the system. That feedback derived from the oversight roles of the American Bar Association and state bar associations, which monitored attorney-client relations, and disciplined attorneys who were noncompliant with administrative and ethical standards, respectively.

The system schematic appears below.

Figure 4-3: System Schematic: Perceptions and Attitudes Toward Counsel



Chapter 5

Discussion and Implications

This chapter contains discussion of the study's three research questions and implications for practice and further study. My subjective opinions and recommendations are based largely on my 27 years of professional experience as a physical therapist and 21 years as an attorney.

Discussion of Research Question 1

The first research question in this study was "What are the attitudes and perceptions of physical therapy education program directors toward consulting legal counsel regarding program-related issues?"

Nine of 20 (45 percent; seven females, two males) respondents professed having positive personal opinions of the law and legal system. Thirteen of 20 respondents (65 percent; eight females, five males) expressed positive personal opinions of attorneys in general.

On the positive side, respondents said that they generally afforded attorneys a high degree of respect. They saw them as educative, expert, fairness-minded, hardworking, honest, open, reasonable, and respectful. On the negative side, some respondents questioned attorneys' ethics generally, and considered them to be insincere and/or self-aggrandizing.

A majority of respondents had positive attitudes toward, and perceptions of, their own consulting legal counsel (60 percent of respondents; seven males, five females). A substantial minority of respondents (40 percent; five females, three males) were relatively unsatisfied with

institutional legal counsel with whom they consulted concerning program-related issues, although they did not articulate the rationale for their opinions very well.

Respondents generally viewed their own consulting legal counsel as adept, available, concise, educative, fair, good listeners and questioners, honest, open, non-condescending, patient, and respectful. The few negative comments about consulting counsel centered on inappropriate delegation of administrative duties back to respondents and procrastination on the part of attorneys regarding clinical contracts.

Of particular interest was the fact that an even stronger majority of respondents (71 percent; five of seven respondents who use outside advisors) expressed general satisfaction with their outside advisors' program-related legal advice.

I believe that the positive attitudes and perceptions of respondents toward attorneys – particularly their own -- contribute to the relative low numbers of health care malpractice and other legal actions brought against physical therapist directors and the academic programs they manage. Such positive attitudes and perceptions facilitate ongoing communication between respondents and counsel, and thereby prevent, minimize, and mitigate legal problems, issues, and dilemmas.

Discussion of Research Question 2

The second research question was "Do the attitudes and perceptions of physical therapy graduate program directors toward consulting legal counsel adversely affect the attorney-client relationship and/or consultation outcomes?".

It has already been demonstrated above that respondents' attitudes and perceptions toward consulting legal counsel directly affected the attorney-client relationship – mainly in a positive way, and to a lesser degree, negatively. Contributing factors for satisfaction and dissatisfaction with consulting legal counsel included all of the comments and factors delineated in the discussion of affinities, interrelationship digraph matrix, and system schematic (Chapter 4). Subaffinities, including: counsel competence and responsiveness; outcomes of conciliation, mediation, arbitration, litigation, and other legal processes; relations between respondents and counsel (confidentiality, cordiality, fiduciary representation, mutual respect and teaching-learning); and whether consultations were conducted proactively and systematically or reactively and *ad hoc*, contributed to respondents' relative degree of satisfaction with consulting legal counsel. Overall, a majority of respondents were highly satisfied with their relationships with consulting legal counsel.

It is less evident that respondents' attitudes and perceptions toward institutional consulting legal counsel substantially affected consultation outcomes. Fourteen of 20 respondents (70 percent; eight females, six males) characterized outcomes of program-related legal consultations as positive. In my opinion, consultation outcomes were positive primarily because of counsels' legal acumen.

On the positive side, respondents reported the following supporting factors for outcomes satisfaction: affirmation of expectations, personal protection of respondents' legal positions, and positive and rational outcomes. On the negative side, respondents reported overkill and the stifling of respondents' desires regarding outcomes on the part of consulting legal counsel.

I believe that these findings support my recommendation that more can and must be done

to optimize attorney-physical therapy program director-client relations. Particularly, I believe that attorneys should avoid substituting their own judgments and values for those of their clients and practice proportionality, to avoid the charge of "overkill" and "stifling clients' desires" in representation and advocacy.

Discussion of Research Question 3

The third and final research question was "What processes can be employed to foster optimal attorney-client relations and consultation outcomes?". Respondent answers to this open question strongly influenced my recommendations offered in this subsection of the dissertation.

I proffer the following suggestions regarding consultative outcomes. First and foremost, effective legal education for education program directors is a requisite to improvement of consultation outcomes. A knowledgeable client is a more effective active participant in legal problem-solving. Such legal education of clients should be provided both during initial orientation of program directors, and systematically and *ad hoc* thereafter on an ongoing basis.

Topics of legal education for physical therapy education program directors should include, in my professional opinion, civil rights, contract law, criminal law, education law (particularly the Family Educational Rights and Privacy Act of 1974 concerning student records), employment law, informed consent, insurance law, intellectual property, the law of health care malpractice, legal ethics, legal research, and regulatory law (Scott, 1997).

I believe in particular that if physical therapy education program directors review actual physical therapy malpractice cases with counsel, then they will minimize legal mistakes and

avoid pitfalls. For example, the case of *Spence v. Todaro* (1994) from the legal literature, raised the issue of an alleged failure on the part of a physical therapist to obtain patient informed consent for intervention. Through study of this case, physical therapy program directors will, in my opinion, be more cognizant of the law and ethics of patient informed consent in their faculty practices. They will also be empowered to more accurately teach their professional students these legal concepts throughout the curriculum. Other cases from the literature present different legal issues (e.g. *Flores v. Center for Spinal Evaluation* (1993)[primary and vicarious liability] and *Hodo v. Basa* (1994)[patient injury from falls, a primary source of malpractice claims and lawsuits; expert witness testimony]), which offer similar opportunities for effective liability minimization.

Additionally, I believe that legal counsel must be cognizant (or made cognizant) of salient physical therapy professional issues. To facilitate this, I believe that physical therapy education program director-clients must educate their attorneys about the practice of physical therapy. I recommend that this be done through the creation of a overview manual, which describes the profession and the education program, its curriculum, clinical affiliations, and faculty practice (as applicable), and profiles its faculty. Directors can then offer the book to consulting counsel for review at the advent of the attorney-client relationship.

I also strongly believe that sufficient numbers of legal counsel to support program director-clients, greater availability of counsel, and particularly, direct access on the part of education program directors to counsel, are crucial to increase attorney-client interaction and to improve client satisfaction with counsel and consultative outcomes.

Regarding attorney-client relations, I offer the following suggestions. Attorneys should

be careful to prevent the inference from arising that they patronize their physical therapy education program-clients. Attorneys should also strive to know these professional clients better in order to instill mutual confidence, and to be more accessible to their clients. Attorneys and clients should be more mutually supportive, and, in particular, work together to ensure the timely and ongoing review of clinical affiliation contracts.

Finally, attorneys should educate and reeducate their clients about their governing canons of ethics, and the nature of confidentiality in attorney-client relations – in particular, who is the actual client in education administration settings. Such disclosure can prevent client misunderstandings about conflicts of interest within a very complex and ever-evolving area of legal ethics.

Implications

Practice

The significance of this study for physical therapy education program directors is that, for the first time, their concerns about their relationships with consulting legal counsel on program-related issues have been articulated. I have presented an initial framework for the improvement of these relations, and for improvement of legal consultative outcomes, based on twenty respondents' input during in-depth interviews. This initial guidance should be augmented by the input of relevant others in the education and legal communities.

I believe that I have made the case for the critical need for more and better-organized

legal education for physical therapy education program directors through this study. I hope that physical therapy education program directors, academic deans, and education administrators will develop formal, appropriately-focused legal education programs for their physical therapy education program directors, or strengthen existing programs. These programs should be initiated upon initial orientation of program directors, and continue systematically and *ad hoc* thereafter on an ongoing basis.

The Commission on Accreditation in Physical Therapy Education should strengthen its legal education program for physical therapist and physical therapist assistant education program directors. Instruction should be imparted on at least an annual basis, most efficaciously at the annual meetings of the Academic Administrators' Special Interest Group (AASIG). This instruction should always include, as typically occurs in continuing legal education programs, an annual pertinent legal issues update.

I recommend that the Commission also consider implementing minimally-intrusive legal education standards for physical therapy education program directors as requisites for program accreditation and re-accreditation. Either the Commission or the Department of Education of the American Physical Therapy Association should also monitor and report on physical therapy education program director satisfaction with consulting legal counsel and consultative outcomes on an ongoing basis, from newly-created input provided by all education program directors in their Biennial Accreditation Reports (BAR's).

Physical therapy education program directors in the aggregate can learn from what their professional colleagues have shared in this study. Optimal attorney-client relations require mutual commitment, respect, education, and support by the parties involved in these processes.

Respondents have provided valuable insight into what they perceive as right and wrong about their relationships with consulting legal counsel, and have suggested a myriad of ways to improve attorney-client relations and consultative outcomes. The fruits of these improvements inure to all parties involved – physical therapy education program directors and their faculty and staff; their attorney consultants; academic administrators; students; patients; and perhaps even, indirectly, the general public, whose presumed negative attitudes toward attorneys might reverse incrementally with positive modeling by physical therapy education program directors, and others similarly situated.

Further Study

In my opinion, this study should be repeated in health professional educational settings besides physical therapy. The collective wisdom of even more respondents would be useful to help further improve attorney-professional client relations.

I also strongly believe that the American Bar Association and state bar associations should take the lead as clearinghouses for receipt, analysis, and dissemination of input by education professional and other clients about their attorney-client relations and consultative outcomes, and offer concrete constructive advice based on this information to attorney-members for their utilization with legal clients – education professionals and all others.

Perhaps sometime in the not-too-distant future, the Shakespearian adage from Henry VI, "First thing we do is kill all the lawyers" may become "First thing we do is consult with our lawyers. They listen to, teach, learn from, and help us."

Bibliography

1. Bailey, D.M. (1991). *Research for the health professional: A practical guide* (2nd ed.) Philadelphia: F.A. Davis.

2. Bennett, J.J. (1997, Feb.). Practicing across state lines, Part 2 . *PT: Magazine of Physical Therapy, 5(2):* 22-25.

3. Bennett, J.J. (1997, Jan.). Practicing across state lines, Part 1 . *PT: Magazine of Physical Therapy, 5(1):* 32-36.

4. Bicentennial Issue (1976). *Physical Therapy*, *56(1):* 1-146.

5. *Black's law dictionary*. (1979). St. Paul, MN: West Publishing Co.

6. Bloom, B.S. (Ed.) (1956). *Taxonomy of educational objectives: The classification of educational goals: Handbook I, cognitive domain*. Toronto: Longmans Green.

7. Campbell, W.G., Ballou, S.V. & Slade, C. (1990). Boston: Houghton Mifflin.

8. Ciotti, P. (1988, August 25). Unhappy lawyers. *The Los Angeles Times,* pp. V1, 8-9.

9. Commonalities and differences between the professions of physical therapy and occupational therapy: An American Physical Therapy Association white paper. (1994). Alexandria, VA: American Physical Therapy Association.

10. Cooperman, J. (2004, March 28). Interview, Ohio Physical Therapy Association, Columbus, Ohio.

11. Crier, C. (2002). *The case against lawyers.* New York: Broadway Books.

12. Davis, K.C. & Pierce, R.J. Jr. (1994). *Administrative law treatise* (3rd ed.). Boston: Little, Brown and Company.

13. Denzin, N.E. & Lincoln, Y.S. (1994). *Handbook of qualitative research.* Thousand Oaks, CA: Sage Publications.

14. DePoy, E. & Gitlin, L.N. (1998). *Introduction to research: Understanding and applying multiple strategies* (2nd ed.). St. Louis: Mosby.

15. de Tocqueville, A. (1840). *Democracy in America*.

16. Erin Brockovich. (2000). Universal Studios, California.

17. *Evaluative criteria.* (2004). Commission on Accreditation in Physical Therapy Education, Alexandria, VA.

18. Family Educational Rights and Privacy Act of 1974, 20 United States Code Section 1232 *et seq*.

19. Fleming, M.H., Johnson, J.A., Marina, M., Spergel, E.L. & Townsend, B. (1987). *Occupational therapy: Directions for the future.* Bethesda, MD: American Occupational Therapy Association.

20. *Flores v. Center for Spinal Evaluation* (1993; Texas Appellate Court). 865 S.W. 2d 261.

21. Furrow, B.R., Greaney, T.L., Johnson, S.H., Jost, T.S. & Schwartz, R.L. (2000). *Health law* (2nd ed.). St. Paul, MN: West Group.

22. *Greening by Greening v. School District of Millard* (1986). 393 N.W. 2d 51 (Nebraska).

23. *Guide for Conduct of the Affiliate Member* (2004). Alexandria, VA: American Physical Therapy Association.

24. *Guide for Professional Conduct* (2004). Alexandria, VA: American Physical Therapy Association.

25. *Guide to Physical Therapist Practice* (1997). Alexandria, VA: American Physical Therapy

Association.

26. Ginsburg, W.H. (1991). How to evaluate a lawyer. *Physician's Management. 12(12):* 90-99.

27. Hammell, K.W., Carpenter, C. & Dyck, I. (2000). *Using qualitative research.* London: Churchill-Livingstone.

28. Harris, M.J. (2000, March 10). Interview, Director, Commission on Accreditation in Physical Therapy Education, Alexandria, VA.

29. Heath, A.W. (1997). The proposal in qualitative research. *Qualitative report. 3(1):* 1-4.

30. Helewa, A.& Walker, J.M. (2000). *Critical evaluation of research in physical rehabilitation.* Philadelphia: W.B. Saunders.

31. *Hodo v. Basa* (1994; Georgia Appellate Court). 449 S.E. 2d 523.

32. Howard, P.K. (1994). *The death of common sense: How the law is suffocating America.* New York: Random House.

33. Kaplan, W.A. & Lee, B.A. (1995). *The law of higher education* (3rd ed.). San Francisco: Jossey-Bass.

34. Katz, L. (1987). *The experience of personal change.* Ph.D. dissertation, Union Graduate School, Union Institute, Cincinnati, Ohio.

35. Keens Steakhouse (1999). New York: Keens.

36. Keeton, W.P. (1984). *Prosser and Keeton on torts.* St. Paul, MN: West Publishing Company.

37. Kearney, K.A. & McCord, E.L. (1992). Hospital management faces new liabilities. *Health Lawyer, 6(3):* 1, 3-5.

38. Lardent, E.F. (1989). *Pro bono* in the 1990s: The uncertain future of attorney volunteerism. In: *Proceedings of the national conference on access to justice in the 1990s.* Chicago: American Bar Association.

39. Larson, C. (2004, March 17). Interview, Director of Professional Standards, Federation of State Boards Of Physical Therapy, Alexandria, VA.

40. Lincoln, Y.S. & Guba, E. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage Publications.

41. Lisante, J.E. (1999, July 20). Okay! I'm getting a lawyer! *The Washington Post,* p. C4.

42. Markey, M.L. & Wisner, C. (2002). Attorney-client privilege in the parent-subsidy relationship. *Health Lawyer News. 6(5):* 5-9.

43. *Model code of professional responsibility and code of judicial conduct.* (1986). Chicago: ABA Center for Professional Responsibility.

44. *Model definition of physical therapy* (1993). Federation of State Boards of Physical Therapy, Alexandria, Virginia.

45. *Model rules of professional conduct.* (1994). Chicago: ABA Center for Professional Responsibility.

46. Murphy, W. (1995). *Healing the generations: A history of physical therapy and the American Physical Therapy Association.* Alexandria, VA: American Physical Therapy Association.

47. Myers, R.S. (1995). *Saunders manual of physical therapy practice.* Philadelphia: W.B. Saunders.

48. Overman, S. (1992). How to work with your lawyer. *HRMagazine. 11(7):* 41-45.

49. Patton, M.Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage Publications.

50. Pelto, P.J., & Pelto, G.H. (9178). *Anthropological research: The structure of inquiry.* Cambridge: Cambridge University Press.

51. Peregrine, M.W. (2004). *Corporate responsibility and the general counsel's office*. Austin: University of Texas School of Law 16th Annual Health Law Conference: April 14-16.

52. Portney, L.G. & Watkins, M.P. (1993). *Foundations of clinical research: Applications to practice.* Norwalk, CN: Appleton & Lange.

53. Press, A., Carroll, G., & Waldman, S. (1995, March 20). Are lawyers burning America? *Newsweek,* pp. 32-35.

54. *Procedural document on disciplinary action.* (2004). Alexandria, VA: American Physical Therapy Association.

55. Public opinion survey of Texans, perception of the justice system. (1999, January). *State Bar of Texas Update.* Austin, TX: State Bar of Texas.

56. *Publication manual* (4th ed.) (1994). Washington, D.C.: American Psychological Association.

57. Richardson, M.L. & White, K.K. (1993). *Ethics applied.* New York: McGraw-Hill.

58. Rosen, J. (2001, February 4). In lieu of manners. *The New York Times Magazine,* pp. 46-51.

59. Rozovsky, F.A. (1990). *Consent to treatment: A practical guide* (2nd ed.). Gaithersburg, MD: Aspen Publishers.

60. Scott, R.W. (2002). *Foundations of physical therapy.* New York: McGraw-Hill.

61. Scott, R.W. (2000). Gender as a factor in physical therapy education program directors' utilization of consulting legal counsel. *Journal of the Section on Women's Health. 24:*4, 7-9.

62. Scott, R.W. (2000). Supporting professional development: Understanding the interplay between health law and professional ethics. *Journal of Physical Therapy Education, 14(3(:* 17-19).

63. Scott, R.W. (2000). Green-light, yellow-light, and red-light circumstances connoting sexual harassment in the workplace – recommendations for professional education. *Journal of Physical Therapy Education, 14(2):* 7-9.

64. Scott, R.W. (1999). *Health care malpractice* (2nd ed.). New York: McGraw-Hill.

65. Scott, R.W. (1998). *Professional ethics: A guide for rehabilitation professionals.* St. Louis: Mosby.

66. Scott, R.W. (1997). *Promoting legal awareness in physical and occupational therapy.* St. Louis: Mosby.

67. Scott, R.W. (1996). Liability awareness: Malpractice update. *PT Magazine.* 4(4):69-70.

68. Scott, R.W. (1990). Instruction on health care malpractice issues in entry-level physical therapy curricula. *Journal of Allied Health. 19:*3, 211-217.

69. Scully, R.M. & Barnes, M.R. (1989). *Physical therapy.* Philadelphia: J.B. Lippincott.

70. Shakespeare, W. (1598). Henry VI.

71. *Spence v. Todaro* (1994, Oct. 14; Eastern District of PA). No. 94-3757.

72. Standards of practice (2000). Alexandria, VA: American Physical Therapy Association.

73. Steinhauer, J. (2001, February 4). Will doctors make your credit sick? *The New York Times,* p. B13.

74. United States Constitution (1789).

75. Volpintesta, E.J. (2000, March 17). 'Lawyer fear' harms health care. *The Wall Street Journal,* A19.

76. Will, G. (2002, June 2). Lawsuit lunacy. *Harrisburg Patriot News,* F4.

Vita

Ronald William Scott was born in Pittsburgh, Pennsylvania on December 19, 1951, the son of Richard Jack and Leone Florence Scott. After completing Penn Hills High School in 1969, Ron enlisted in the Navy as a hospital corpsman during the Vietnam War, and served as an operating room technician in Charleston, South Carolina; Rota, Spain; Jacksonville, Florida; and aboard the U.S.S. Holland (AS-32), a nuclear submarine tender.

In August 1973, Ron married his wife, Maria Josefa Barba Garces, a native of El Puerto de Santa Maria, Spain, port city for the construction and embarkation of Columbus' *Santa Maria* ship. After his honorable discharge from the Navy in November 1973, Ron earned his Bachelor of Science degree *Summa Cum Laude*, from the University of Pittsburgh, Pennsylvania, with a certificate in physical therapy.

Ron again volunteered for active duty military service with the Army in August 1978, and went on to be stationed at Fort Leonard Wood, Missouri; Frankfurt, Germany; Fort Polk, Louisiana; and Fort Sam Houston, Texas. He served in the JAG Corps and Army Medical Specialist Corps, and retired with 20 years active service in July 1994 as a Major, having earned two Meritorious Service Medals.

Ron earned five additional degrees during and after his military service, including: Master of Arts, Spanish, Millersville University, Pennsylvania; Master of Science in Business Administration, Boston University; Master of Science, Orthopedic Physical Therapy, Samuel Merritt College, Oakland, California; Master of Law, Military Law, The JAG School, Charlottesville, Virginia, and Juris Doctor, *Magna Cum Laude*, University of San Diego,

California. While in law school, Ron was Lead Articles Editor for the San Diego Law Review, and coordinated the 23rd Law of the Sea Symposium for the journal.

Ron has spent his working career as a health law attorney-litigator/mediator, orthopedic physical therapist, and educator. He was Associate Professor at the University of Health Science, San Antonio, Texas, from 1994-1998 and Interim Chair from 1995-1996. His current university faculty affiliations include: Husson College, Bangor Maine; Northern Arizona University, Flagstaff, Arizona; Rocky Mountain University, Provo, Utah; Shenandoah University, Winchester, Virginia; Webster University, San Antonio, Texas; and the University of Indianapolis, Indiana.

Ron has authored seven books: *Foundations of physical therapy* (McGraw-Hill, 2002); *Legal aspects of documenting patient care*, eds. 1 & 2 (Aspen, 1994, 2000); *Health care malpractice*, eds. 1 & 2 (McGraw-Hill, 1990, 1999); *Professional ethics* (Mosby, 1998); and *Promoting legal awareness* (Mosby, 1997). He has also written seven book chapters, the most recent being "Legal issues" in *Complementary therapies and wellness* (Carlson, J., Prentiss-Hall, 2003). Ron has also authored 64 scholarly articles, the most recent being "Physical therapists as consultants to elder law attorneys and clients, *Journal of Elder Law* (Marquette University School of Law, 3(3): 11-13 (2003)).

Ron and Maria celebrated their 31st anniversary on August 5, 2004. The have two sons, Ron, Jr., a musician and poet, and Paul, a 6th grade math teacher. Paul is married to Amanda (Killins) Scott, who is an 8th grade English teacher. Ron and Maria's first precious grandchild – Isabel Reese, was born to Amanda and Paul on December 10, 2003.

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This dissertation was typed by the author.